

November 17, 2017

Administrator Seema Verma
U.S. Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Director Brian Neale
The Center for Medicaid and CHIP Services
U.S. Centers for Medicare and Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Dear Administrator Verma and Director Neale:

The Arizona Health Care Cost Containment System (AHCCCS), Arizona's single State Medicaid agency, serves as a model of the benefits of managed care, having achieved considerable recognition and national attention over the decades through the innovative practices, design, and flexibility of its comprehensive health care delivery system.

Consistent with one of its founding principles, AHCCCS has operated as a public-private partnership predicated on competition, choice, and efficiency. Today's climate presents opportunities to further innovate and modernize Arizona's Medicaid program to meet the needs of the state's unique population. The key to transforming Medicaid in Arizona is the ability to move away from rigid and outdated federal prescriptions that hamper state and private sector innovation. Our state must be afforded sufficient discretion to craft a program that provides the highest-quality health care possible in the most efficient manner.

Arizona received the letter to the Governors expressing the U.S. Department of Health and Human Service's commitment to enhance such innovation and flexibility. Arizona proposes the following policies that we believe would build on our past successes and allow us to continue to build a strong Medicaid program that leverages conservative principles. AHCCCS is outlining these proposals to begin dialogue with the Centers for Medicare and Medicaid Services (CMS) on these important issues; formal waiver submittals will follow where necessary and appropriate.

Empowering Arizonans to Gain Education, Training, and Employment

It is well-recognized that the determinants of health include social and economic factors including education and employment. We must support Arizonans in pursuing their educational goals, building their technical skills, and gaining the income, independence, and fulfillment that come with employment.

To further this objective, Arizona proposes that able-bodied members (defined as physically and mentally capable of working and not medically frail) who are at least 19 years old and fall within the definition of SSA1902(a) (10)(A)(i)(VIII) ("Group VII" members) verify that they are employed, attending school, attending an Employment Support and Development program, or any combination of these, for at least 20 hours per week.

Certain individuals would be exempt from this requirement, including those who are: at least 55 years old; American Indians; women up to the end of the month in which the 90th day of post-pregnancy occurs¹; former Arizona foster youth up to age 26; individuals determined to have a serious mental illness (SMI); individuals currently receiving temporary or permanent long-term disability benefits from a private insurer or from the government; full-time high school students who are older than 18 years old; full-time college or graduate students; victims of domestic violence; individuals who are homeless; individuals who have recently been directly impacted by a catastrophic event such as a natural disaster or the death of a family member living in the same household; a parent, kinship caregiver, or a foster parent of a child under 13 years of age; a caregiver of a family member who is enrolled in the Arizona Long Term Care System; or determined medically frail consistent with A.R.S. § 36-2903.09. This comprehensive list of exemptions was informed through a robust public engagement process that resulted in AHCCCS receiving hundreds of comments from various stakeholders.²

Members subject to this requirement who do not qualify for an exemption and fail to show 20 hours per week of employment, school, or Employment Support and Development activities will receive a 6 month grace period to enable them to achieve the requirements. Failure to comply after the grace period will result in a termination of AHCCCS enrollment; however, members may re-enroll once they can demonstrate compliance for 30 consecutive days.

The definition of an Employment Support and Development program would include job training programs, English as a Second Language courses, parenting classes, disease management education, courses on health insurance competency, and healthy living classes. For individuals who are transitioning from the justice system, living in an area of high unemployment, or who otherwise face a significant barrier to employment, community service hours may count towards the required 20 hours per week.

AHCCCS will work with the Arizona Department of Economic Security (DES) to leverage existing programs that support Arizonans on their path to employment and will create new supports to empower our citizens. This will require an investment to scale existing programs and enhance infrastructure. Arizona would look to leverage Medicaid funding to support these enhancements designed to ensure AHCCCS enrollees have opportunities to meet the employment requirements we are proposing. The gains in education and employment that will result from this initiative will facilitate and enhance positive health outcomes for Arizonans.

Similarly, Arizona will put processes and procedures in place, including data sharing among state agencies and programs, to ensure that determinations as to whether members are meeting employment and community engagement requirements are made efficiently.

Arizona plans to submit a formal waiver amendment request regarding this proposal by December 31, 2017. Pursuant to A.R.S. § 36-2903.09, this submission will include a request to place a lifetime limit of five years of benefits on able bodied adults who are subject to the requirement described above but are not meeting the requirements and do not qualify for an exemption.

¹ Arizona currently provides coverage to Title XIX eligible women through the month in which the 60th day of the postpartum period occurs. AHCCCS may work with the state legislature to expand eligibility for SOBRA women through the month in which the 90th day of the postpartum period occurs.

² Please note that by limiting these policies to Group VIII, many of these individuals automatically do not fall under the work requirement provisions by virtue of their eligibility category; however, we are noting their exemption here for transparency purposes.

Aligning Medicaid with Commercial Insurance Policies for Non-Disabled Adults

Traditional Medicaid was designed to serve children, pregnant woman, the elderly, and individuals with disabilities. Today, AHCCCS serves nearly as many adults (with or without dependents) as it does Arizonans enrolled in the traditional eligibility categories. Federal laws that require Medicaid services to be comparable in amount, duration, and scope for all mandatory and optional individuals have hindered the state's ability not only to pilot experimental programs but also to target benefits to those populations most in need. Accordingly, Arizona would like to seek the following flexibilities.

Limit Non-Emergency Medical Transportation (NEMT) Services:

Federal requirements mandate that states provide NEMT to all Medicaid beneficiaries. Arizona would like to modify the NEMT benefit, potentially including a waiver from the state wideness and comparability requirements in order to recognize those populations and areas of the state that have limited other transportation options. Specifically, Arizona would like the flexibility to restrict NEMT benefits for certain able-bodied adult members who are not medically frail with income equal to 100-138% of the FPL living in an urban area (as defined by the State).

Flexibility to Implement Pre-ACA Retroactive Coverage:

Under current policy, if a new AHCCCS member received AHCCCS covered services and would have qualified for AHCCCS coverage during any portion of three months immediately preceding the month in which the member applied for AHCCCS coverage, AHCCCS will reimburse the providers for those services. Arizona would like to request the flexibility to limit this retroactive coverage to the month of application, consistent with how Arizona treated eligibility prior to passage of the Affordable Care Act. We appreciate that CMS recently has granted several states' requests for flexibility surrounding retroactive coverage.

Modernizing Medicaid Prescription Drug Benefits

Arizona is concerned by the statutory limitations it faces in addressing the rapidly growing prescription drug expenditures in recent years. Federal statute requires the State Medicaid program to include in its formulary the covered outpatient drugs of any manufacturer that has entered into an agreement with the Secretary of the Department of Health and Human Services (HHS) under the Medicaid Drug Rebate Program. While states may use prior authorization under the drug rebate program, these tools are limited in scope compared to the more competitive strategies used by private payers and Medicare to manage prescription drug costs.

Pharmacy is a significant cost pressure in state Medicaid programs. From FFY 2014 to FFY 2016, AHCCCS' pre-rebate spending on pharmaceuticals dispensed by pharmacies increased from \$786.6 million to \$1.2 billion. The per-member, per-year spending increased from \$747 to \$1,061, an increase of 42 percent.

In an effort to modernize the management of Medicaid prescription drug benefits, Arizona would like to seek input from CMS on flexibilities Arizona could pursue relating to the requirement to cover every breakthrough drug upon the manufacturer's inclusion of the drug under a rebate agreement. States should be permitted the flexibility to exclude drugs until market prices are consistent with reasonable fiscal administration and sufficient data exists regarding the cost effectiveness of the drug, without losing the Medicaid Drug Rebate.

Furthermore, Arizona should be permitted to exclude drugs when it's Pharmacy and Therapeutics (P&T) Committee has determined that the drug does not have a significant, clinically meaningful, therapeutic advantage in terms of safety, effectiveness, or clinical outcome over another drug on the State's formulary. Arizona will cover at least two drugs per drug category or class, unless (1) only one drug is available for a particular category or class, or (2) only two drugs are available in a category or class but one drug is clinically superior to the other, consistent with Medicare Part D requirements.

Modernizing & Stabilizing Federally Qualified Health Center Reimbursements

The payment methodology for Medicaid reimbursement of Federally Qualified Health Centers (FQHCs) is outdated and unsustainable. While FQHCs serve as an important partner in our Medicaid delivery system, cost-based reimbursement mechanisms drive up the cost of care. From 2009 to 2017, when most Arizona provider rates have held relatively stable or decreased, the required reimbursement rates for FQHCs in Arizona have risen by 50 percent as a result of the misaligned incentives inherent in cost-based reimbursement. In addition, requirements regarding paying for all services provided by FQHCs result in certain benefits being covered in those settings which are not otherwise covered Medicaid services. Finally, the federal requirements around FQHC reimbursement limit our ability to drive value-based arrangements with these important providers.

While we recognize that aligning FQHC rates to market rates would impact their ability to serve as important safety net providers, modest reforms to the reimbursement structure are critical to provide predictability and stability to our budget and ensure sufficient resources for our program. Arizona requests the discretion to freeze the current FQHC base payment rates and to choose the most appropriate inflation factor for the year at issue, which may include the price change for Medical Care in the Consumer Price Index. We also request the flexibility to require the managed care organizations we contract with to reimburse FQHCs at this rate.

Current law requires Medicaid programs to increase FQHC base payment rates if a FQHC demonstrates that an adjustment in the scope of services is not covered by the base rates. Arizona would like to pursue relief from this mandate, but maintain the ability to decrease FQHC base payment rates if a FQHC reduces its scope of services, whether this would be through a waiver or another flexibility identified by the administration.

Arizona is also interested in fostering predictability as to what services AHCCCS must cover. Under a 9th Circuit Court ruling, Arizona's Medicaid program must cover all services provided by FQHCs even if those services are not included in our State Plan and would not be covered in another facility. This is inequitable and circumvents the state's decision-making regarding what benefits it covers for its members, decisions that are made within the federal parameters of the Medicaid program. Members should not have a different benefit package based on the provider they choose to see. Arizona would benefit from the increased predictability that would result from a waiver of this requirement.

Rebalancing the Federal-State Medicaid Partnership

The establishment of heightened federal standards and reporting requirements over the past few years has disrupted the delicate balance between Federal oversight and state flexibility. Specifically, Arizona would like to request regulatory relief with respect to the Access to Care Rule.

As a mandatory managed care program, Arizona has a very limited fee-for-service (FFS) program. We are concerned that the burdensome requirements of this rule outweigh the value that can be expected for

states with small FFS populations. Furthermore, the majority of the individuals in Arizona's FFS program are American Indians. These members typically receive services through Indian Health Service (IHS) and Tribal 638 facilities, which have policies and rates that are set by the federal government, including rules on what data is collected to help facilitate monitoring. While we are always held to the overarching requirement of ensuring member access to care, the detailed data collection and reporting required by the rule is disproportionately burdensome and is complicated by a lack of data reporting from our IHS and 638 providers. Therefore, we would like to request that Arizona be exempt from the Access to Care Rule requirements. We would be happy to work collaboratively with CMS to demonstrate that we are effectively monitoring access to care for our members that is better reflective of our entire population.

Streamlining the Waiver Approval Process

Arizona was the last state to implement Medicaid but the first state to implement mandatory managed care. We have operated our managed care program since the program's inception in 1982, yet every 5 years we must undertake extensive stakeholder engagement and negotiations with the federal government merely to continue operating the same successful program. We are very encouraged by the information bulletin CMS released outlining how CMS intends to improve the 1115 waiver approval process by increasing transparency and efficiency. We would like to propose how this guidance can apply to Arizona.

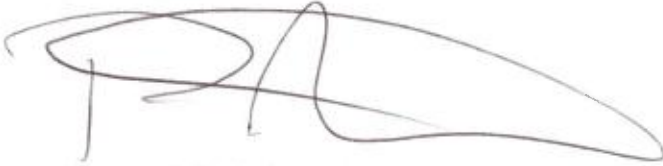
Specifically, CMS stated in the guidance that it may approve the extension of routine, successful, non-complex section 1115(a) waiver and expenditure authorities for a period up to 10 years. The information bulletin also indicated CMS' interest in paving a streamlined path to renewal for demonstration projects that are less complex and have been running smoothly. Arizona has operated a very successful Medicaid program under a Section 1115 waiver for more than three decades. Over these decades, CMS has rigorously evaluated, and consistently found to be effective, Arizona's historical waiver authorities. For this reason, we request that CMS provide an expedited path to renewal and approve for a period of 10 years all of Arizona's waiver authorities that CMS has approved at least two times, which include the following:

- Authorities that permit the state to restrict freedom of choice of providers through mandatory enrollment of eligible individuals in managed care;
- Authorities that permit the state to limit certain managed care enrollees' choice of plans to a single Managed Care Organization;
- Authorities associated with the provision of Home & Community Based Services (HCBS) to individuals enrolled in the Arizona Long Term Care System (ALTCS);
- Authorities that relieve the state from the requirements of section 1927(g) of the Social Security Act (the "Act") pertaining to drug utilization review;
- Expenditures for outpatient drugs which are not otherwise allowable under section 1903(i)(10) of the Act that have not undergone a drug utilization review;
- Expenditures for payments to participating IHS and tribal 638 facilities for categories of care that were previously covered under the State Medicaid plan, furnished in or by such facilities; and
- Expenditures under contracts with managed care entities that do not provide for payment for Indian health care providers as specified in section 1932(h) of the Act, when such services are not included within the scope of the managed care contract, as well as expenditures for State payments for services furnished to managed care enrollees by Indian health providers, when those payments are offset from the managed care capitation payment.

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Director Brian Neale
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We look forward to working with you to modernize Arizona's Medicaid program and empower the state's most vulnerable citizens. Thank you for your consideration.

Sincerely,

A handwritten signature in black ink, appearing to read 'T. Betlach', with a large, sweeping flourish extending to the right.

Thomas J. Betlach
Director