AHCCCS
Arizona Health Care Cost Containment System

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

January 4, 2016

VIA ELECTRONIC SUBMISSION TO: http://www.regulations.gov

Centers for Medicare & Medicaid Services (CMS)
Department of Health and Human Services
P.O. Box 8016
Baltimore, MD 21244-8016

Re: ***Arizona Comments to:***
File Code CMS-2328-FC; Final Access to Care Rule and
File Code CMS-2328-NC; CMS Request for Information (RFI), both Published November 2, 2015

To Whom It May Concern:

The Arizona Health Care Cost Containment System (AHCCCS), Arizona's single state Medicaid agency, is grateful for the opportunity to provide comments to the final rule concerning a "standardized, transparent, data-driven process for states to document that provider payment rates are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area…" (the "Final Rule").

I. Arizona Comments to Final Rule: Inapplicability to Managed Care States

The Final Rule addresses a key area of importance with respect to any state Medicaid program's ability to achieve quality health outcomes for our members – that provider networks must be in place to meet membership needs. States that have provided member services through a managed care model have long followed a series of federal regulations and contractual principles that address the very same issues. In Arizona, contracted managed care organizations (MCOs) must follow multiple requirements around network adequacy designed to ensure members have access to Medicaid covered services. These standards define access to care in a number of different ways, such as physical proximity of the member to providers and time to scheduled appointments, among others.[1]

Accordingly, the focus of the Final Rule is on fee-for-service (FFS) populations for whom network adequacy standards have not heretofore applied. In Arizona, the two FFS populations that are not covered by managed care are: (1) American Indian/Alaska Native members that elected FFS enrollment in the American Indian Health Program; and (2) individuals who are not eligible for full Medicaid services because they do not meet the citizenship requirement and, therefore, are only eligible for Federal Emergency Services (FES). The Final Rule, as a practical matter, is largely inapplicable to the FES

[1] See, e.g., *AHCCCS Contractor Operations Manual (ACOM)*, Chapter 400, Policy 415, Attachment B Network Development and Management Plan Checklist available on the AHCCCS website last accessed January 4, 2016 at http://www.azahcccs.gov/shared/ACOM/Chapter400.aspx. See also ACOM Policy 436 for Network Standards. See also "Access to Care 2015 Projection for FFY 2015" available on the AHCCCS website last accessed January 4, 2016 at: http://www.azahcccs.gov/commercial/Downloads/rates/AccessToCare2015_Web.pdf.

population since this group accesses most services for treatment of an emergency medical condition at hospitals.[2]

The remaining FFS population in Arizona is American Indian/Alaska Native (AI/AN) members who enroll in AHCCCS on a FFS basis. Approximately 75% of the AI/AN AHCCCS enrolled population receive services on a FFS basis. In Arizona, this equates to approximately 120,000 members out of the 1.85 million Arizonans served by AHCCCS – less than 7% of the AHCCCS membership.

In Fiscal Year 15, AHCCCS paid approximately $576 million to Indian Health Services (IHS) and Tribal 638 Facilities, where most AI/AN FFS enrolled members receive their care.[3] Most of the services paid to IHS and Tribal 638 Facilities are paid at the All Inclusive Rate, a rate set nationally by the federal government. Claims submitted by IHS and Tribal 638 Facilities lack the appropriate level of detail in order for states to meet the Final Rule reporting requirements. Very little information is captured on claims submitted by IHS and Tribal 638 Facilities. While Arizona supports monitoring access to care, the requirements as set forth in the Final Rule are simply beyond the reach of states. If CMS is interested in securing information regarding access to care for the AI/AN FFS population, it must redirect its efforts to work with its federal partners so that the appropriate data can be captured by IHS and Tribal 638 Facilities. In addition, CMS should engage in tribal consultation around obtaining additional data for members living on sovereign lands over which the states have no jurisdiction.

Accordingly, Arizona agrees with the comments submitted by the National Association of Medicaid Directors (NAMD) and believes that:

1. ***States with a significant majority of their membership enrolled in managed care should be exempted from the Final Rule's requirements; and***
2. ***Populations that are not fully under a state's authority, such as the AI/AN population, should be exempted from the Final Rule requirements*.**

II. Arizona Comments to Request for Information (RFI): Developing Appropriate Access to Care Standards

As many more states move toward Medicaid managed care, it is important to align existing requirements and to limit the number of measures so as to better focus specifically on critical areas that will demonstrate how the health care delivery system is performing. As we move toward value based payment arrangements, the same underlying principles should be applied in measuring access to care: the focus must be on quality and not quantity.

Below are some of Arizona's comments to questions posed in the RFI.

[2] Including the 11 Indian Health Services/Tribal 638 facilities, there are 118 hospitals in Arizona, and 115 are registered with AHCCCS to provide services.

[3] Approximately two-thirds of paid amount for services provided to the AI/AN FFS enrolled population is spent on IHS and Tribal 638 Facilities. The remaining one-third is nearly all hospital spend for specialty care that is not available through IHS and Tribal 638 Facilities.

A. Access to Care Data Collection and Methodology

What do you perceive to be the advantages and disadvantages to requiring a national core set of access to care measures and metrics? Who do you believe should collect and analyze the national core set data?

- It is important to establish a limited number of national core measures focused on critical areas to demonstrate how the health care delivery system is performing. The core measure set does need to include methodologies that address variations in systems, such as rural versus urban or acute versus long term care, as these look very different due to practitioner availability. How different populations access care is also important – e.g., acknowledging differences for children, adults and aged, blind or disabled individuals.
- The federal agencies should collect and analyze the core data set submitted by states. This would also drive improvement in claims/encounter data submission to CMS.

Do you believe there are specific access to care measures that could be universally applied across services? If so, please describe such measures.

- Potentially yes, there are some options for universal measures. Access to a primary care provider (PCP), for instance, should be universal to all populations and ages. In addition, some preventive health measures are critical, such as well visits for children and adults. Inappropriate use of the emergency department could also be an indicator of a potential lack of access to care or lack of education regarding how and where to access available services.

What information and methods do you believe large health care programs use to measure access to care that could be used by the Medicaid program? What role can health information technology play in measuring access to care?

- Large insurers utilize standardized measure sets as proxies for measuring access to care. For example, evidence-based care recommendations for chronic disease or well visits are utilized to determine access to chronic disease care such as diabetes, asthma, and annual well visits for adults. Other proxies measure emergency department utilization, particularly inappropriate use of the emergency department, as an indicator of lack of access to a PCP. There is also movement for measuring access to care through use of extended office hours and use of urgent care rather than emergency room utilization, though these measures are really in their infancy.

What do you believe are the primary indicators of access to care in the Medicaid program? Is measured variance in these indicators based on differences in things such as: Provider participation and location, appointment times, waiting room times, call center times, prescription fill times, other?

- The primary indicators of access to care are provider participation based on population size served by the Medicaid program, appointment availability, delays in obtaining appointments, and number of providers accepting new patients.

Do you believe a national core set of access measures or metrics should apply across all services, or is it more appropriate to target a core set of access measures by service?

- It would be most appropriate to target a core set of measures by service. Core measures must be by service type and preferably focusing on primary care services. There is a lot of variability with respect to specialty services, such as expectations based on condition, healthcare status of the individual being served, evidenced-based guidelines for care, etc. Access to specialists would create unique challenges for measurement purposes. Access to oral health should be

included as a national measure as much work has been done nationally by Medicaid programs to improve access to care.

Do you believe questions in provider and beneficiary surveys should be consistent for Medicaid and Medicare beneficiaries? If not, what differences do you believe should be accommodated for the Medicaid program, including differences in covered services?

- There are some differences between Medicaid and Medicare programs, copays, how claims are paid, covered services, populations covered, etc. Consequently, for national core measures, the experience of care survey (e.g., CAHPS) questions should focus on more universal access to care questions rather than access to specific specialty services – e.g., ability of the member to access a primary care provider within the timeframe needed.

What do you believe we should consider in undertaking access to care data collection in areas related to: Differences between fee-for-service (FFS) and managed care delivery, variations in services such as acute and long-term care, community and institutional settings for long-term care delivery, behavioral health, variations in access for pediatric and adult populations and individuals with disabilities, and variations in access for rural and urban areas? Consider also individuals with chronic conditions who may have limited functional support needs related to activities of daily living but nonetheless require more intensive care than other Medicaid beneficiaries, such as persons living with HIV/AIDS.

- Access to care measurements should be based on evidence-based care guidelines, including recommendations for frequency of service as determined by national medical associations, such as the American Academy of Pediatrics. For instance, children need much more frequent visits than a healthy adult. Access to care measurements for individuals with a chronic condition similarly should be based on professional recommendations for their disease state.
- Rural/urban considerations should be included as urban areas often have a higher concentration of providers, though specialty providers may often still be very limited. This is also important because the measure is specific to access to care to the extent that the service is available to the general (non-Medicaid) population.
- For members that receive long-term care services and supports (LTSS), there is an opportunity to use measures around access to supports that allow members to remain in the community, such as attendant care or personal care.

Specific to long-term services and supports, including home and community based services, what factors do you believe we should consider in measuring access to care? Do you believe we should incorporate into reviews of access to care for these services economic factors and significant policy factors such as: Minimum wage and overtime requirements, direct service worker shortages, training and professional development costs, or other factors?

- Measures should focus on outcomes and accessibility of supports that allow people to remain in the community. This includes measures related to system capacity and alternative residential settings that can adequately support members with complex medical and behavioral health needs in the community.
- Although Medicaid programs must adapt to external factors like minimum wage and overtime requirements to ensure an adequate network to meet member needs, ultimately utilization data and health outcomes are the true measures for access to care.

Do you believe measuring access to Home and Community Based Services (HCBS) differs from measuring access to acute medical care? Please describe.

- The same standards pertaining to network capacity (e.g., number of providers, credentials of providers, scope of services) and accessibility (timeliness to access the service, distance to provider, etc.) all apply to HCBS and acute medical care services alike. For HCBS, the measures should be based on approved services, such as attendant care or personal care services and whether the service delivery (quantity, frequency, quality) met the needs of the individual to allow them to remain in a less restrictive setting (community setting).
- Core measures for HCBS must be population based, but experience of care surveys can include questions that are more individual based, such as accessibility of a provider that can assist the member in meeting their own individualized goals.

Do you believe access to HCBS should be tracked in FFS and in managed care delivery systems? Do you perceive any differences between tracking HCBS in each system?

- Arizona strongly urges exclusion of managed care populations from the Final Rule for the reasons set forth in this correspondence. In a managed care environment, MCOs have a responsibility to assist members with accessing care, sending reminders of care needs, scheduling appointments, providing transportation to and from appointments, providing medication assistance, etc. These issues are contractually required and monitored for compliance. There are opportunities for corrective action plans and sanctions in a managed care environment. There is more structure and accountability in the managed care environment. In a FFS environment, the responsibilities fall largely on the member and their family to schedule appointments, work through barriers to care, and coordinate transportation. Methods for addressing barriers to accessing care are distinct. Certainly both systems can measure similar member outcomes, but they are not the same.

Do you believe there are additional metrics that need to be tracked related to HCBS?

- HCBS measures should include those that reflect the outcomes from HCBS services, such as ability to remain in the community (e.g., length of time in community setting versus skilled nursing).

B. Access to Care Thresholds/Goals

Do you believe we should set thresholds for Medicaid access to care? If so, do you believe such thresholds should be set at the national, state or local levels? Why?

- Access to care thresholds should be based on state or local levels and based on rural versus urban, at a minimum. Population characteristics, population density, provider capacity, provider penetration, etc., all vary state by state as well as within states. Arizona, the fourteenth most populous state, includes one of the country's largest metropolitan areas (Phoenix) but is nonetheless comprised of extensive rural and frontier areas.

If we set Medicaid access thresholds, how do you believe they should be used? For instance: For issuing compliance actions to states that do not meet the thresholds, as benchmarks for state improvement, for use in appeals processes for beneficiaries that have trouble accessing services, or in other ways?

- Medicaid access thresholds should be used as benchmarks and for states to develop improvement goals when opportunities are identified. Arizona already has a standardized practice in place for those members who have issues accessing services in their area.

C. Alternative Processes for Access Concerns

We are considering requiring standard access to care complaint driven processes to better ensure access and are interested in how data gathered and analyzed through a core set of measures might aid in resolving complaints, please consider the following questions:
-Do you believe there are existing and effective processes to resolve consumers' concerns regarding health care access issues that might be useful for all state Medicaid programs?
-What do you believe are the advantages and disadvantages of either a complaint resolution process or a formal appeals hearing for access to care concerns?
-Who do you believe should be the responsible party (for example, the state or federal government, an independent third party, a civil servant, an administrative law judge, etc.) to hear beneficiary access to care complaints and/or appeals?
-For an access to care appeal, what criteria do you believe should be used to help determine:
++Whether an appeal should be heard?
++Whether an appeal merits recommendations to the state Medicaid agency?
-Which access to care areas of measurement or specific metrics may be useful in setting thresholds that would help hearings officers assess appeals and determine access to care remedies?
-Lack of timeliness of an appeal could undermine the time sensitive efforts associated with remediating an individual's access to medical services.
-You may want to consider providing information on the following:
++How could appeals be expedited?
++What outcomes could an appeals officer offer if services are unavailable to Medicaid beneficiaries?

- For purposes of this response, Arizona is assuming that by "formal appeals hearing" CMS is referring to a process similar to that described in 42 CFR Part 431, Subpart E and/or Part 438, Subpart F – that is, a due process hearing which affords an individual beneficiary the opportunity to present testimony and evidence to a neutral third party for the purposes of adjudicating facts, applying the law to those facts, and ordering relief when appropriate. With respect to access to care issues, Arizona questions whether use of such a formal appeals hearing process would provide efficient or effective relief to individual beneficiaries for a number of reasons. It is Arizona's position that a formal appeals hearing or similar process, such as presentation to an independent panel, is not an effective mechanism for addressing these matters. In the event that a formal appeals or similar process is mandated by CMS, exemptions should be made available to states with high managed care populations or extensive rural geographic areas, as examples.
- The relevant legal standards for access to care do not lend themselves to establishing clearly articulable individual rights – that is, the standards are applicable to systems of care rather than to individual rights to access. Both 42 USC 1396a(a)(30)(A), regarding access to care in a fee-for-service environment, and 42 USC 1396u-2(b)(5), regarding access to care under managed care, speak in terms of access assessments based on "populations" and "expected enrollment" rather than in terms of assurances of individual access. In *Armstrong v. Exceptional Child Center, Inc.*, 135 S.Ct. 1378 (2015), the United States Supreme Court held that individual beneficiaries and providers do not have a private right of action to challenge compliance with the access to care

provisions. The vast complexity associated with enforcement of the broad and non-specific provisions of Section 30(A) was fundamental to the Supreme Court's opinion. A reasonable inference from the holding of *Armstrong* is that the adequacy of access to care must be evaluated on a system-wide rather than individual basis. Individual administrative appeals are no more likely than individual law suits to provide meaningful application of the statutory access standards in individual cases for the same reasons set forth in that decision. For the reasons that the Supreme Court in *Armstrong* concluded that the standards in Section 30 (A) are "judicially unadministratable," Arizona finds the same rationale applicable to resolution of access to care disputes through individual appeals. An individual appeals process with formal hearing rights, including an evidentiary hearing, is not unlike the judicial process unavailable through Section 30 (A).

- Participation in a state Medicaid program by health care providers is voluntary. While the access provisions of the Medicaid Act clearly impose obligations on participating states to facilitate broad provider participation, states lack authority to compel individual providers to participate in the Medicaid program, to compel those providers who do elect to participate to provide services to individual beneficiaries, or to compel those providers who do participate to provide services to individual beneficiaries within set time frames. It is unlikely that state legislatures would ever contemplate mandating participation in Medicaid as a condition of state licensure due to the negative impact such a requirement would have on the health care system available to state citizens generally. Even if the state elected to impose maximum panels or wait-times through state statute or contract with participating providers, inclusion of such requirements would have the opposite effect on access to care as those requirements would be disincentives for providers to participate in the state Medicaid program. As a result, administrative law judges lack the authority to order individual providers to resolve the access issues of individual beneficiaries.
- Administrative orders directed at the state Medicaid program (or Medicaid managed care entities) are unlikely to provide adequate and prompt relief to individual beneficiaries. The appeals process is not well-suited to prompt resolution of access issues where it is not unusual for months to elapse before issuance of a final administrative determination given the statutory requirements for advance notice and decision making timeframes. Although expedited resolution timeframes may require more immediate resolution in theory, Arizona's experience with expedited service appeals repeatedly finds that members frequently request delays for appeal preparation or to enlist the participation of necessary witnesses or experts. For this and other reasons discussed, Arizona advocates for a less formal process to resolve individual access concerns.
- In some instances, access to care problems stem from insufficient Medicaid participation by health care providers who are otherwise available to the general population in the relevant geographic area. In other instances, issues with access to care stem from insufficient health care provider capacity to serve the general population (including Medicaid beneficiaries) in the geographic area. Nevertheless, it is possible that Medicaid programs, such as Arizona's, represent the care that *is* available to the general population, which may preclude access issues

through application of Section 30 (A). While the state may have tools to address issues associated with insufficient program participation by available health care providers (such as rate adjustments, expanded provider outreach and education, and/or streamlining processes for provider enrollment and claims processing), the Medicaid program has only a limited capacity to affect change in the capacity of the health care delivery system that is available to the general public. In addition, the tools available to the state to affect change in provider participation and/or the delivery system generally will take time and, to the extent they are effective, will produce changes in the system over time. The available tools are not well suited to offering specific relief to individual beneficiaries filing administrative appeals.

- Conversely, Arizona has found that a less formal complaint resolution process is effective in assisting individual beneficiaries with the resolution of access to care issues. In many, if not most instances, the root cause of individual beneficiaries' access to care problems can be most effectively and efficiently resolved through the application of basic case management/care coordination activities. That is, the problem often stems from a failure to adequately access the medical needs of the individual, to identify the options available to address those medical needs and the health care providers available to promptly provide care, and to connect the beneficiary with the most appropriate provider. In that regard, AHCCCS Contractors are responsible for sophisticated and robust care management and care coordination activities, including those which pertain to members with special health care needs, which often are critical in addressing member access concerns. Contractors make available services through telehealth and telemedicine to address access issues in geographically remote areas of the state. Member advocacy councils at the Contractor level represent another effective resource available to members to present care delivery and access to care issues.
- While managed care contractors have primary responsibility for providing this type of assistance through the grievance resolution process established in regulation and contract, the state Medicaid agency also accepts complaints regarding quality of care including access to care issues. While such complaints are routinely referred to the enrollee's managed care contractor, the state Medicaid agency also maintains oversight of the resolution of the individual issues that are brought to it. In addition, Arizona has also found it beneficial to require managed care entities to track and trend access to care issues separately from other types of beneficiary grievances. Managed care contractors are required to establish plans, take action, and document activities and progress when access to care issues are identified that effect their enrollees. The state, through its contracts with managed care entities, requires each contractor to report this information on a regular basis, which enables the state to both monitor the performance of individual managed care contractors but also to identify access to care issues that may be effecting Medicaid beneficiaries system-wide.
- Arizona employs other mechanisms to evaluate access to care that further diminish the necessity for an individualized appeals process. The state continuously measures provider participation at a statewide level, with particular consideration of participation in rural areas, to monitor provider access generally. Arizona also imposes mandatory reporting by every

Contractor to identify instances when a provider that serves 5% or more of the population, or which serves a designated population, no longer participates. In this manner, Arizona is able to identify potential access issues throughout the state and institute measures to address access at the earliest opportunity. In addition, MCOs can employ single case agreements and direct a member to receive care from an out-of-network provider where no in-network provider is available.

D. Access to Care Measures

1. Measures for Availability of Care and Providers

- These measures should be state specific. Geographic Service Areas should minimally be defined as Urban, Rural, and Remote or Frontier.

Primary care physicians (including pediatricians) and clinicians accepting any/new patients.

- This measure should include physician extenders, such as nurse practitioners and physician assistants.

Physician specialists accepting any/new patients.

- Maintaining a perspective with respect to access of these providers to the general population is important. For example, some specialists are in high demand and are low in quantity in many states. Often panels are closed, not just to the Medicaid population but also to the general population. With Medicaid managed care, MCOs are required to assure access to care. In many cases, MCOs arrange single case agreements or send patients out-of-network to ensure care needs are met. It is challenging to capture these expectations in a broad based methodology.

Specialty care (for example, addiction and psychiatric services, home and community based services, specialty pharmacy) accepting any/new patients.

- These services are based on an individual's person-centered care plan as opposed to broad based services that apply universally to all members. Measurement of these specialty areas may be better captured through an experience to care survey rather than a data measurement.

Availability of direct support workforce for home health and home and community-based services.

- Consideration should be given to outcomes measures for determining availability of direct support workforce for HCBS services. In a managed care environment, MCOs are required to meet the needs of the member so the outcomes from that requirement would be the best indicator of availability.

Dentists accepting any/new patients.

- Providers often do not update MCOs on whether they are closing their panel. Therefore, this will be a challenging measure to capture accurately. The current processes used by Insure Kids Now, for instance, do not accurately reflect the dental provider status. Utilization measures would be a better indicator or a question in the experience of care survey (CAHPS).

Psychiatric and substance abuse clinicians such as psychiatrists, child psychiatrists, psychologists, and psychiatric social workers and mental health counselors accepting any/new patients.

- Utilization measures or timely access to care as reported in an experience of care survey would be better indicators of access to behavioral health professionals.

Physicians and clinicians experiencing difficulties referring patients to specialty care.

- In a Medicaid managed care program, the question on the provider survey would need to be specific to experience in referring patients to an IN-NETWORK specialty care provider versus the specialty provider that they would routinely refer to.

Psychiatrists experiencing difficulties referring patients with serious mental illness to primary care.

- Access to PCP measures may be good standardized measures. Provider surveys may also be a good proxy to capture the provider experience.

Available primary care clinics, federally qualified health centers or rural health clinics.
Available retail community pharmacies.
Available behavioral health clinics or community mental health centers.
Available inpatient care.
Other.

- Access to care measures should be across all provider settings for primary care and not separate out private practices from federally funded providers. Time and distance standards for pharmacies, behavioral health services (all types) and inpatient providers makes sense but should not be stratified by unique types.

2. <u>Measures for Beneficiary Reported Access</u>

Unmet need for specialty, primary, follow-up, dental, prescriptions, and mental health and substance abuse treatment due to cost concerns.

- Measures need to be based on covered services for the state program (e.g., limitations or exclusions, such as for adult dental, must be taken into account).

Beneficiaries getting needed care quickly.

- This is a standard question on the CAHPS survey, but it does not reflect the health care need; rather it reflects what the member wants in term of timeliness.

Length of delays in accessing long term services and supports in community setting due to direct service worker shortages and/or lack of adequate training.

- This would be challenging for a member to respond to as they would not necessarily be informed about the specific reason for a delay in accessing long term services or supports.

Call-center capability standards to support providing beneficiaries with information that can improve their access, and produce useful metrics for monitoring.

- Arizona captures this information on grievance reports, including first call resolution.

3. Measures Regarding Service Utilization

Trends in emergency room utilization relative to primary and mental health and substance abuse treatment care utilization.

- Measures need to include consideration for appropriate use of the ED. Also, time of day would be important as routine primary care and behavioral health services and often urgent services may not be offered by the individual's provider outside of regular business hours.

Rates of utilization (for example, at least one of the following visits in the prior six months/year: Physician (including nurse practitioners and physician assistants), dental, specialty, behavioral health, and primary care/well-child.)

- Arizona recommends measures be age and condition specific as the recommended preventive health visit schedules differ. Dental may not be a covered benefit for adults in all states, and if it is, there may be limitations.

Other.

- Other measures that may be considered include: follow-up after discharge; medication reconciliation for long term care or after discharge; all cause readmissions; average length of stay by condition; chronic disease utilization measures for recommended care and services; inpatient or emergency department utilization for individuals diagnosed with a chronic condition; inpatient psychiatric stay for certain behavioral health conditions managed in an outpatient setting; and medication adherence. For prenatal, use of the HEDIS standardized measures (also part of the CMS core set) would be beneficial.

4. Comparison of Payments

Payment rates for services set at a specific percentage of Medicare.
Medicaid payment rates compared to surrounding states, Medicare, commercial payers.

- Comparisons to surrounding states can be useful when applied selectively and with awareness that geographic proximity is not always an indicator of similarity in economy, population, and the cost of health care. Arizona frequently performs reimbursement rate comparisons with the neighboring states of Nevada and New Mexico, both reasonably similar to Arizona and whose health care facilities are utilized by Arizona Medicaid members. However, the neighboring state of California is so dissimilar on all three points as to render comparisons meaningless for most purposes. The value of these comparisons may also be diminished by differences in law and policy among the states, particularly where reimbursement rates in one or more states may be influenced by purchasing contracts. Given the number and variety of factors impacting reimbursement rates, it is questionable whether state-to-state rate comparisons yield meaningful information about access to care.
- Comparisons to Medicare are already routinely performed. The usefulness of such comparisons in the context of access to care is limited by the dissimilarity in Medicare and Medicaid member populations – e.g., insignificant numbers of children/pregnant women on Medicare may mean that Medicare's rates are not appropriate for Medicaid.

- Comparisons to commercial payers are infeasible, as commercial payers do not make their reimbursement rates available for public inspection.

Acquisition costs compared to Medicaid payments for pharmaceuticals.

- As a general concept, this comparison is reasonable. Implementation of it is made challenging by the difficulty in obtaining reliable information on acquisition cost and by the volatility of drug prices. For example, Average Wholesale Price – a widely used index – is calculated differently by the various data outlets. Any such broad average necessarily fails to accurately capture the impact of purchasing contracts, situational discounts, drug rebates and 340B pricing, all of which combine to create large differences in acquisition costs among health care providers, even among providers of the same type. The movement of drug pricing in the market can mean that a reimbursement rate, determined adequate at the beginning of a fiscal year, may be generous or inadequate by the end of that year. For pharmaceuticals, finding a comparison point that yields a meaningful statement about access to care may be infeasible.

Comparisons or measures that would inform managed care rate adequacy (the payment managed care plans make to providers).

- The best measure of managed care rate adequacy is the willingness of providers to contract with the managed care organization. Arizona Medicaid actively monitors the number of providers who leave an MCO's network due to dissatisfaction with reimbursement rates. In Arizona, managed care contracts require that contractors providing acute care services have a network that is sufficient to provide covered services within designated time and distance limits. Long-term care contractors are required to contract with a sufficient number of providers of specific types to provide the full range of Medicaid long-term care services. Arizona monitors each contractor's compliance with network standards through quarterly and annual deliverables and annual network plans submitted by each contractor. Arizona also performs regular operational 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.
- As part of its statewide managed care program, Arizona conducts robust contract management activities on an ongoing basis with particular focus directed to access to care for Medicaid members. Additional measures or other requirements may be superfluous. Arizona recommends using a measure similar to what Arizona currently uses – i.e., the number or rate of providers leaving the Medicaid program (or MCO) due to rates. As we drive MCOs toward value based payment arrangements, states are basing payment on quality performance. MCOs need to have the flexibility to establish appropriate payment rates that support quality outcomes.

In conclusion, Arizona appreciates the opportunity to provide input with respect to one of the core principles of the AHCCCS program – ensuring an adequate network to meet the needs of our members. This Final Rule should apply only to the FFS programs that have not undergone the same level of structure as Medicaid managed care. In addition, CMS must consider factors that extend beyond the control of states, such as lack of transparency in claims data submitted by key provider groups like Indian Health Services and Tribal 638 Facilities.

I hope Arizona's feedback on what measures are important is helpful. It is critical to maintain a focus in developing these measures. Maintaining a focused approach will not only limit the number of measures but will achieve the goal of truly monitoring access to care. Based on Arizona's experience, tracking utilization data and health outcomes are at the heart of that focus.

If you have any questions or need additional information, please do not hesitate to reach out to me.

Sincerely,

Thomas J. Betlach
Director