Georgetown University
Health Policy Institute
CENTER FOR CHILDREN
AND FAMILIES

November 23, 2015

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

**Re: Arizona Proposed Amendment to Arizona Health Care Cost Containment System 1115 Waiver Demonstration - Safety Net Care Pool Extension/Arizona Proposal for Section 1115 Research and Demonstration Waiver-Arizona Healthcare Cost Containment System**

Dear Secretary Burwell,

Georgetown University Center for Children and Families appreciates the opportunity to provide comments on Arizona's proposed extension and five-year phasedown of the Safety Net Care Pool (SNCP). This comment letter responds to both the SNCP section of the proposed Section 1115 Research and Demonstration Waiver, as well as the proposed amendment for a one-year extension of the SNCP.

First, a five-year extension, as requested in the Section 1115 proposal, should not be granted because this specific request is an extension of an existing SNCP agreement. Section 1115(e)(2) of the Social Security Act only allows extensions of existing demonstrations for three-year periods.

Secondly, extending an uncompensated care pool like the SNCP should be examined carefully in the larger context of the state's health coverage programs, principally the state's unwillingness to reinstate comprehensive coverage for many children with federal funding available through the federal Children's Health Insurance Program (CHIP). Arizona's request to continue this SNCP—even as a phase-down—does not comply with principles the Centers for Medicare & Medicaid Services (CMS) set forth in its May 21, 2015 letter in reference to Florida's Low-Income Pool.[1] These principles are analogous in some ways to the situation facing Arizona children – some of whom will likely remain uninsured as a result of the state's refusal to open its CHIP program as described below.

As Arizona is requesting an extension for SNCP, the state is refusing to accept full federal funding to re-open its CHIP program, KidsCare, which was frozen in 2010 and subsequently re-opened under KidsCare II as a key condition of the original SNCP agreement in 2012. KidsCare II sunset in January 2014 with the full implementation of the Affordable Care Act

[1] See letter from CMCS Director Wachino to Florida AHCA Secretary Justin Senior on May 21, 2015.

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and new marketplace plans. Yet, 2014 data reveal that Arizona children still need KidsCare. Arizona stayed, for the fifth year running, near-bottom among states (49th) in its rate of uninsured children (10 percent), with about 162,000 remaining uninsured.[2] Children in the income range for the dismantled KidsCare program were uninsured at an even higher rate (16.5 percent), ranking Arizona last for children between 138 and 200 percent of the federal poverty level (FPL).[3]

While new qualified health plans offer an important opportunity for uninsured Arizonians with no previous access to coverage, they, unlike CHIP, were not designed with children in mind and include additional cost barriers and benefit gaps by comparison. A 2014 cost comparison of KidsCare versus a sampling of Arizona's marketplace plans shows that in most cases families would pay significantly more for their children's marketplace coverage.[4] Further, families who previously relied on KidsCare could be locked out of marketplace coverage entirely due to the "family glitch."[5]

We support the principle that your department articulated first to Florida and later to other states that coverage, rather than uncompensated care pools, is the most effective way to secure affordable access to health care. The recent CHIP extension in the Medicare Access and CHIP Reauthorization Act (MACRA) allowed for an increase in Arizona's enhanced federal medical assistance percentage in CHIP to 100 percent.[6] This would allow the state to re-open KidsCare and fully serve children between 138 and 200 percent of the federal poverty line at no cost to the state through at least federal fiscal year 2017. Accepting CHIP funds would not only extend coverage to more uninsured children; it would also reduce uncompensated care costs for the state's health care system overall, not simply one hospital.

Arizona Health Care Cost Containment System (AHCCCS) justifies the SNCP extension, in part, by claiming the sole SNCP beneficiary, Phoenix Children's Hospital (PCH), serves a relatively high rate of Medicaid-covered patients coverage and a low proportion of uninsured patients. Yet, the state's decision to discontinue KidsCare impacts the full system of health providers who could benefit from available federal funds through CHIP. Reinstating CHIP and the federal funds available through the program could provide an additional opportunity to restructure state payments across all public programs and providers.

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[2] J. Alker and A. Chester, "Children's Health Insurance Rates in 2014: ACA Results in Significant Improvements" Georgetown Center for Children and Families (October 2015), available at http://ccf.georgetown.edu/

[3] Georgetown Center for Children and Families analysis of 2014 U.S. Census, American Community Survey data.

[4] T. Brooks, M. Heberlein, and J. Fu, "Dismantling CHIP in Arizona: How Losing KidsCare Impacts a Child's Health Care Costs" Georgetown Center for Children and Families and Children's Action Alliance (May 2014), available at http://ccf.georgetown.edu/

[5] *Ibid.*

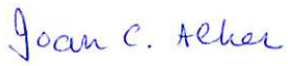
[6] "Federal Financial Participation in State Assistance Expenditures; Federal Matching Shares for Medicaid, the Children's Health Insurance Program, and Aid to Needy Aged, Blind, or Disabled Persons for October 1, 2015 Through September 30, 2016," *Federal Register,* 79: 71426 – 71427 (December 2, 2014).

Finally, we also support CMS's stated principle that managed care payments (and ultimately provider payments) must be actuarially sound and adequate to ensure prompt access to needed services by beneficiaries.[7] We understand this principle to mean that direct capitation payments tied to individual Medicaid beneficiaries – rather than supplemental payments – are the preferred mode of federal financial support. We assume that CMS shares this view with respect to the CHIP program. This principle helps to protect against geographic, economic, and other inequities that can arise with supplemental payment structures that target a limited number of providers or structure payments based on local financing sources.

We understand that health system transformation and new payment models can be a challenge for hospitals serving large numbers of Medicaid beneficiaries, especially children with complex health needs. We believe CMS and the state have multiple tools at their disposal—including the reinstatement of CHIP – to ensure that provider payments are adequate to meet the needs of beneficiaries.

Thank you for your consideration of our comments. Please contact Elisabeth Burak (Elisabeth.Burak@georgetown.edu) or Joan Alker (jca25@georgtown.edu) with any questions or if you need additional information.

Sincerely,



Joan Alker
Executive Director

[7] May 2015 Letter from Wachino to Senior states, "Provider payments must be sufficient to promote provider participation and access, and should support plans in managing and coordinating care."