

Janet Napolitano, Governor
Anthony D. Rodgers, Director



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February 15, 2008

The Honorable Henry A. Waxman
Chairman
Committee on Oversight and Government Reform
U.S. House of Representatives
2157 Rayburn House Office Building
Washington, DC 20515

Re: Impact of Medicaid regulatory changes

Dear Chairman Waxman:

Thank you for your interest in the impact to states of the recent Medicaid regulations proposed and promulgated by the Centers for Medicare and Medicaid Services (CMS). As the Director of the Arizona Health Care Cost Containment System (AHCCCS), the Arizona state agency that administers the state's Medicaid program, I have been very concerned about the impact these rules will have on Arizona and its Medicaid members.

In your letter, you requested an analysis of the impact to Arizona of the following regulations:

- Cost Limits for Public Providers (proposed 72 Fed. Reg. 2,236; final, 72 Fed. Reg. 29,748);
- Payment for Graduate Medical Education (proposed, 72 Fed. Reg. 28,930);
- Payment for Hospital Outpatient Services (proposed, 72 Fed. Reg. 55,158);
- Provider Taxes (proposed, 72 Fed. Reg. 13,726);
- Coverage of Rehabilitative Services (proposed, 72 Fed. Reg. 45,201);
- Payments for Costs of School Administration and Transportation (proposed, 72 Fed. Reg. 51,397; final, 72 Fed. Reg. 73,635); and
- Case Management (Interim Final Rule, 72 Fed. Reg. 68,077).

Specifically, you requested an analysis of the impact of each proposed rule, including an estimate of the expected reduction in federal Medicaid funds to Arizona over each of the next five years and an estimate of the effect of this reduction on Medicaid applicants and beneficiaries in Arizona. Each of these is discussed below. For your reference, I have also attached copies of comments submitted to CMS by AHCCCS.

Cost Limits for Public Providers

While we do not have a direct fiscal impact estimate associated with this regulation to Arizona, we expect the impact to be significant. This proposed regulation will add extensive administrative and bureaucratic costs to the health care system in our state. Providers ranging

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from public hospitals to schools and local ambulance units will feel the burden of this process. CMS already oversees the rate setting process associated with providing services. Now this rule demands annual tracking of payments compared to cost. Ultimately the burden and risk for providers may prove insurmountable and AHCCCS is concerned that important stakeholders will leave the system rather than put up with the cumbersome requirements of this regulation.

Payment for Graduate Medical Education

In recent years, Arizona has been identified by the U.S. Census Bureau as the nation's first or second fastest growing state. Because its physician workforce has not grown in proportion to the state's population, the state is facing an imminent workforce shortage. Researchers at the Arizona State University and the University of Arizona found that Arizona had 20.7 physicians per 10,000 people, substantially below the national average of 28.3.

Medicaid funding of graduate medical education (GME) is a critical component of Arizona's plan to address this shortage. As part of this plan, Arizona has linked GME payments to hospitals directly to the establishment of new residency positions, so a loss of GME would result in a loss of residency positions in the state. We project the following losses in funding:

	State	Federal	Total
FY09	\$15,398,400	\$30,105,000	\$45,503,400
FY10	\$15,822,000	\$30,400,600	\$46,222,600
FY11	\$16,075,500	\$30,887,800	\$46,963,300
FY12	\$16,336,700	\$31,389,600	\$47,726,300
FY13	\$16,605,700	\$31,906,400	\$48,512,100
5 year total	\$80,238,300	\$154,689,400	\$234,927,700

This loss will exacerbate the physician shortage problem, possibly resulting in reduced access to physicians, greater pressure to increase physician reimbursement rates, and lower quality of care.

Payment for Hospital Outpatient Services

The new restrictions on hospital services could be costly for hospitals, since some services would no longer be reimbursable as outpatient hospital services; nor would they be included in the calculation for outpatient hospital upper payment limits or disproportionate share hospital payments. Arizona is waived from the upper payment limit requirements if its fee-for-service payments remain less than 5% of service expenditures, so no direct financial impact is anticipated for this portion of the regulation.

Provider Taxes

Arizona's only provider tax is a tax on premiums of managed care organizations; however, at 2%, Arizona's premium tax is well below the proposed limits. Therefore, we do not anticipate a direct impact on costs or members, and we did not comment on the proposed rules.

Coverage of Rehabilitative Services

The option to cover rehabilitative services is the basis for many of Arizona's outpatient adult behavioral health programs. Some of the behavioral health services Arizona provides under the rehabilitative services option include screening, assessment, and evaluation; counseling, including individual, groups, and family therapy; behavior management; peer support; living

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skills training; and medication management. These services are essential to enable adults with mental illness to maintain function and reside in the community rather than inpatient settings.

It has been difficult to determine the financial impact of the proposed rules on AHCCCS services; however, it appears that the impact will be predominantly administrative. The rules appear to increase administrative costs associated with onerous and duplicative planning and documentation. The rules would impact about 86,000 acute care members.

Payments for Costs of School Administration and Transportation

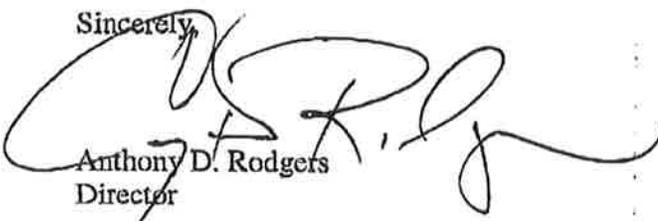
Arizona's Medicaid administrative claiming program reimburses local education agencies for outreach and administrative activities. This program will be eliminated in its entirety under the final rules. Further, the proposed rules will eliminate reimbursement for transportation between home and school for Medicaid services delivered on school grounds. It is estimated that these rules would result in a loss of revenue of \$4.0 million for administration and \$7.7 million for transportation annually, or \$20 million for administration and \$38.5 million for transportation for fiscal years 2009 to 2013. There are approximately 30,000 children receiving school-based Medicaid services in Arizona. Because these services are protected by IDEA, it is likely that the students will continue to receive the needed services; however, all of Arizona's students are likely to experience the impact of these rules as schools are forced to cut programs to adjust to the loss of funding.

Case Management

The impact of the interim final rule for case management and targeted case management is unclear. Arizona's managed care case managers provide access to medical, educational, social, and other services; however, they also act as gatekeepers, restricting access to services that are not medically necessary. Individualized case management by the managed care entity has the potential not only to control costs, but also to produce better health outcomes for members. While the preamble to the proposed rules distinguish managed care case management from services under the case management option, the distinction is not evident in the proposed rule. Arizona may be forced to cease case management functions not specifically related to the management of medical services, to the detriment of its members.

Again, thank you for your time and interest. If I can be of further assistance, please contact me at (602) 417-4111 or anthony.rodgers@azahcccs.gov.

Sincerely,



Anthony D. Rodgers
Director

Attachments: March 16, 2007, letter to CMS (cost limits for providers)
June 22, 2007, letter to CMS (graduate medical education)
October 12, 2007, letter to Mr. Kerry Weems (rehabilitative services)
October 29, 2007, letter to Mr. Kerry Weems (hospital outpatient services)
October 31, 2007, letter to Mr. Kerry Weems (school based administration)
February 4, 2007, [sic, 2008] letter to Mr. Kerry Weems (rehabilitative services)



Our first care is your health care
ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

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Office of Intergovernmental Relations
(602) 417-4534 • Fax (602) 256-6756

TO: Chairman Henry A. Waxman

COMPANY: House Committee on Oversight and Government Reform

FAX#: (202) 225-4784

FROM: Robert Lindley

- COMMENTS: Please find attached the following documents:
- February 15, 2008, letter to Chairman Waxman
 - March 16, 2007, letter to CMS (cost limits for providers)
 - June 22, 2007, letter to CMS (graduate medical education)
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DATE: 2/15/08 TIME: 11:48am NUMBER OF PAGES 25
Including Cover

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ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

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March 16, 2007

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-2258-P
P.O. Box 8017
Baltimore, MD 21244-8017

RE: File Code CMS-2258-P

Please accept the following questions and comments from the Arizona Health Care Cost Containment System (AHCCCS), the single state agency responsible for administering Arizona's Medicaid program, in response to the portion of the Federal Register Notice of January 18, 2007 (72 FR 2236) applicable to 42 C.F.R. Parts 433, 447, and 457.

For ease of review, AHCCCS has organized its response by general topic, with the proposed Federal requirements initially stated and the correlating question or comment thereunder.

Retention of Payments

42 C.F.R. § 447.207, as proposed, would require all providers "to receive and retain the full amount of the total computable payment provided to them under the approved State plan or approved provisions of a waiver or demonstration if applicable."

- The preamble to the proposed rule at 72 FR 2242 explains that the purpose of this section is to strengthen efforts to remove any potential for abuse involving the re-direction of Medicaid payments by Intergovernmental Transfers ("IGTs") in the future. The section itself, however, makes no reference to IGTs. 42 C.F.R. § 447.207 should be clarified such that the provisions only apply to situations in which an IGT is involved.
- During a phone call with the States on January 25, 2007, CMS indicated that an expenditure must have occurred before a unit of government can certify an expenditure to the Medicaid agency. That expenditure could either be in the form of: 1) a payment by a unit of government to a provider, or 2) a governmental provider incurring expenses associated with the delivery of care. In either case, CMS indicated that once a unit of government certifies a "valid" expense, the provider has been paid. There is concern that the proposed retention requirements make it possible for a governmental provider to assert it is entitled to 100% of the FFP returned to the State on the basis of its expenditure, and the State's retention of any of the FFP constitutes a violation of this proposed rule. 42 C.F.R. § 447.207 should be clarified to clearly state:

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- Once a governmental provider certifies an expenditure, the retention of payments as required by the proposed rule has been satisfied.
- The distribution of FFP from the Medicaid agency to any certifying unit of government is not a relevant factor in measuring compliance with the proposed rule.
- The State may withhold a portion or the entire amount of FFP resulting from a CPE.
- Health care providers may be subject to taxation, licensing, and other fees that are generally applied to the private sector or to the health care industry at large. There is some concern that the proposed rule would enable providers to assert that they should not be subject to normal operating expenses, which have no direct connection to Medicaid, in as much as they are required to retain the full amount of the total computable payment. 42 C.F.R. § 447.207 should be clarified to:
 - Clearly state that "normal operating expenses including taxes, licensing, other fees associated with the cost of conducting business that are unrelated to Medicaid and in which there is no connection to Medicaid payments" are not affected by the retention requirements of the proposed rule and are not included in the calculation of a State's net expenditures.
- The proposed requirement to retain full payments conflicts with the provisions of Section 1903(w) (codified at 42 U.S.C. §1396b) which clearly contemplates that providers can return certain portions of payments as bona fide donations and permits certain qualifying health care taxes. 42 CFR §447.207 should be clarified to:
 - Clearly allow donations and taxes as permitted by Section 1903(w) even if a Medicaid payment is the source of those donations or tax payments.

Managed Care Organizations

At 42 FR 2236, the preamble to the proposed rule states that the provisions related to cost limits do not apply to Medicaid Managed Care Organizations ("MCOs") or SCHIP providers. At 42 FR 2240, the same cost limit exception for MCOs and SCHIP providers is repeated. However, nowhere else in the proposed rule are MCOs mentioned. There is confusion as to the meaning of the phrase "except that Medicaid managed care organizations ... are not subject to the cost limit provision of this regulation." The preamble and wherever appropriate in the proposed rule should be clarified to:

- Specifically indicate that MCOs, including prepaid inpatient health plans, are not subject to the proposed rule's cost limitation requirements with respect to both a State's payment to a MCO and to a MCO's payment to governmental providers.

Pursuant to proposed 42 C.F.R. § 447.206(c)(1) and subject to exceptions related to Indian Health Service and tribal facilities, "all health care providers that are operated by units of government are limited to reimbursement not in excess of the individual provider's cost of

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providing covered Medicaid services to eligible Medicaid recipients." The language does not seem to provide an exception for payments made by MCOs. 42 C.F.R. § 447.206 should be clarified to:

- Specifically state that the section does not apply to payments made by MCOs to health care providers that are operated by units of government.

Pursuant to proposed 42 C.F.R. § 447.272(b)(4) and subject to exceptions related to the Indian Health Service, tribal facilities, and Disproportionate Share Hospitals, Medicaid payments to State government operated facilities and non-State government operated facilities must not exceed the individual provider's cost. 42 C.F.R. § 447.272(b)(4) should be clarified to:

- Specifically state that the section does not apply to payments made by MCOs to health care providers that are operated by units of government.

Proposed 42 C.F.R. § 447.321(b)(4), which largely mirrors 42 C.F.R. § 447.272(b)(4), limits Medicaid payments for outpatient services to the individual provider's cost. 42 C.F.R. § 447.321(b)(4) should also be clarified to:

- Specifically state that the section does not apply to payments made by MCOs to health care providers that are operated by units of government.

Disproportionate Share Hospitals (DSH)

Pursuant to proposed 42 C.F.R. § 433.51(b)(3), CPEs must at a minimum "demonstrate the actual expenditures incurred by the contributing unit of government in providing services to eligible individuals receiving medical assistance or in administration of the state plan." With respect to DSH, it is unclear whether DSH payments are *services to eligible individuals receiving medical assistance* or are payments *in administration of the state plan*. 42 C.F.R. § 433.51 should be clarified to:

- Indicate how and where DSH payments fit into proposed rule requirements.

Proposed 42 C.F.R. § 447.206(c)(1) states that "all health care providers that are operated by units of government are limited to reimbursement not in excess of the individual provider's cost of providing covered Medicaid services to eligible Medicaid recipients". One of the purposes for DSH payments is to help ensure that States provide adequate financial support to hospitals that serve a disproportionate number of low-income patients with special needs. Therefore DSH payments are not solely made to *provide covered Medicaid services to eligible Medicaid recipients*. When read literally, this section appears to prohibit DSH payments for low income patients with special needs. 42 C.F.R. § 447.206 should be clarified to:

- Specifically recognize DSH in the cost limit provision of the rule.

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Proposed 42 C.F.R. § 447.272 and 42 C.F.R. § 447.321 set forth the application of upper payment limits to inpatient services and to outpatient hospital and clinical services respectively. Whereas, 42 C.F.R. § 447.272 contains exceptions for IHS and DSH, 42 C.F.R. § 447.321 contains an exception only for IHS. There is concern that this omission may prohibit or restrict DSH payments for outpatient hospital services. 42 C.F.R. § 447.321 should be clarified to:

- Provide the same exception for DSH as contained in 42 C.F.R. § 447.272.

The preamble to the proposed rule at 72 FR 2239 specifies that tax revenue contractually obligated between a unit of State or local government and health care providers to provide indigent care is not considered a permissible source of non-Federal share funding for purposes of Medicaid payments. The example fails to recognize that a tax levied to support indigent care and is ultimately used to reimburse a hospital for its provision of inpatient services for indigent care, may serve as the basis for that government unit's CPE for DSH purposes. The preamble should be clarified to:

- Indicate that the use of taxes levied to support indigent health care can serve as the basis for CPE for DSH purposes.

Administrative Burden

CMS has indicated its disapproval when States make Medicaid payments in excess of costs to governmentally operated providers as it is considered inconsistent with the principles of economy and efficiency. As such, the proposed rule at 72 FR 2241 seeks to limit reimbursement to actual costs for governmental providers. In order to effectuate cost-limited reimbursement, governmental providers would be required by the proposed 42 C.F.R. § 447.206 to utilize a cost report or other auditable documentation. Additionally, 42 C.F.R. § 433.51(b)(3), 42 C.F.R. § 447.272, and 42 C.F.R. § 447.321 would be changed to conform with cost-limited reimbursement requirements.

The application of the proposed rules to all Medicaid programs and all governmental providers is overly broad and imposes administrative burdens and expenses in situations where abusive practices are unlikely to occur. CMS should consider providing exemptions to the proposed rules in the following circumstances:

- *Exemption for entire Medicaid programs.* In circumstances where fee for service payments to governmental providers constitutes only a small percentage of a State's total medical assistance payments (e.g., less than 5%) due to either the widespread use of managed care or the relative lack of governmental providers, the entire Medicaid program should be exempt from the rules. 42 C.F.R. §§ 433.51(b)(3), 447.206, 447.272, and 447.321 should all be amended to:

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- Exempt a State and its governmental providers from their provisions when the percentage of a State's fee for service payments to governmental providers constitutes less than a certain percentage of total medical assistance payments.
- *Exemption for governmental providers paid based on a fee schedule applicable to both governmental and non-governmental providers.* As described at 72 FR 2241, the requirement for cost-limited reimbursement is based, in part, on CMS' concern that payment in excess of cost is flowing to governmental providers and is either being used to subsidize health care operations unrelated to Medicaid or returned to the State as an additional source of revenue. A reimbursement system in which a single rate schedule is applied to governmental and non-governmental providers alike, and no supplemental payment is made to governmental providers except for DSH and GME, would appear to assuage this concern. Additionally, such a reimbursement system would serve to encourage economy and efficiency in governmental providers. As such, in the event the proposed exemption described in the previous bullet is unacceptable as overly broad, 42 C.F.R. §§ 433.51(b)(3), 447.206, 447.272, and 447.321 should alternatively be amended to:
 - Exempt governmental providers from their provisions when the State's reimbursement system applies the same fee schedule to all providers of the service in the State (or in a region) and no supplemental Medicaid payment is made in addition to the fee schedule except for DSH and GME.
- *Exemption for governmental providers receiving only a nominal amount of payments and paid based on a fee schedule applicable to both governmental and non-governmental providers.* The requirement to utilize a cost report or other auditable documentation will cause a hardship on governmental providers that only receive a nominal amount of Medicaid payments. In fact, the costs incurred by a governmental provider associated with establishing and maintaining a cost report could, in certain situations, exceed total Medicaid payments received by the governmental provider. For example, fire districts often provide ambulance services, and ambulances sometimes attend to Medicaid recipients. Associated reimbursement may be on a fee-for-service basis. School districts also provide critical services as part of the State Plan and the administrative burden imposed, on particularly smaller districts, by the proposed regulations, could effectively end their ability to receive Medicaid reimbursement. The blanket application of the rule to all governmental providers, regardless of the total amount of reimbursement received, prohibits a State's compliance with the economy and efficiency provisions of Section 1902 (a)(30)(A) of the Act, which is the very issue CMS seeks to resolve. Furthermore, where the cost of establishing and maintaining a cost report exceeds the Medicaid reimbursement, governmental providers may decline to participate in the program. As such, in the event the proposed exemptions described in the previous bullets are overly broad, revenue thresholds should be included in order for cost reporting requirements to apply. Accordingly, 42 C.F.R. §§ 433.51(b)(3), 447.206, 447.272, and 447.321 should all be amended to:
 - Exempt governmental providers from the provisions of the proposed rules if:

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- The governmental provider is reimbursed on a fee schedule that is faced by all providers of the service in the state (or in a region) and no supplemental Medicaid payment is made in addition to the fee schedule except for DSH and GME;

And

- The governmental provider receives Medicaid payments that are less than a fixed amount during a fiscal year (e.g., \$500,000), or less than a fixed percentage amount of the entire operating budget of the governmental provider (e.g., 5% of the total revenue of the government).

As described at 72 FR 2241 and in the proposed 42 C.F.R. § 447.206(d), regardless of whether or not a Medicaid cost reimbursement payment system is funded by CPEs, governmentally-operated providers must file annual cost reports. The definition of provider contained in 42 C.F.R. § 433.50(a)(1), which is referenced by 42 C.F.R. § 447.206(d), does not specifically mention professional services. Therefore, the cost reporting requirements of licensed professionals (e.g., physicians, nurses, therapists) that are employed by, and bill under the provider number of, public entities are not sufficiently clear. In order to protect professional service providers from the administrative burden associated with having to report costs, and the State from the administrative burden associated with having to review the cost reports of professional services providers, 42 C.F.R. § 433.50(a)(1) and 42 C.F.R. § 447.206(d) should be amended to:

- Exempt professional service providers under the employ of, or billing under the provider number of, a unit of government.

Also as described at 72 FR 2241 and in the proposed 42 C.F.R. § 447.206(d), under a Medicaid cost reimbursement payment system funded by CPEs, States may utilize most recently filed cost reports to develop interim Medicaid payment rates and may trend these interim rates by an applicable health care-related index. Interim reconciliations must be performed by reconciling the interim Medicaid payment rates to the filed cost report for the spending year in which interim payment rates were made. Final reconciliation must also be performed by reconciling the interim payments and interim adjustments to the finalized cost report for the spending year in which interim payment rates were made.

- In general, the process described above is administratively burdensome for both the Medicaid agency and the governmental provider. The procedure outlined in the proposed 42 C.F.R. § 447.206(e) is less burdensome in that it only mandates a single "review" when CPEs are not being used to fund payments to governmental providers. 42 C.F.R. § 447.206 should be amended to:
 - Eliminate the methodology for payment currently set forth in 42 C.F.R. § 447.206(d), in favor of having the methodology set forth in 42 C.F.R. § 447.206(e) apply to both CPE and non-CPE scenarios.

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Timeframe for Compliance

Currently, States must comply with the proposed rule by September 1, 2007. The date is referenced in proposed 42 C.F.R. § 447.206(g), 42 C.F.R. § 447.272(d)(1), and 42 C.F.R. § 447.321(d)(1). Because State legislative authority is a prerequisite to compliance with many of the provisions set forth therein, either a transition period should be established or the September 1, 2007 deadline should be extended. 42 C.F.R. §§ 447.206(g), 447.272(d)(1), and 447.321(d)(1) should be amended to:

- Permit States up until September 1, 2008 to fully comply with the provisions of the proposed rule.

Thank you for the opportunity to comment on the proposed rule. Should you have any questions, please do not hesitate to contact Tom Betlach at (602) 417-4483.

Sincerely,



Anthony D. Rogers
Director

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Anthony D. Rodgers, Director



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June 22, 2007

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

Re: File Code CMS-2279-P

Thank you for the opportunity to review and comment on the proposed rules prohibiting the use of federal Medicaid funds to support graduate medical education (GME) as published in the Federal Register on May 23, 2007 (72 Fed. Reg. 28930). The State of Arizona strongly supports CMS continuing to allow states to utilize Medicaid funds to support GME programs' direct and indirect costs. State Medicaid programs cannot assure adequate health care access without strategic policy tools like GME.

As Director of the Arizona Health Care Cost Containment System (AHCCCS), Arizona's single State Medicaid Agency, I submit the following comments pertaining to those rules.

Summary of policy rationale to oppose the proposed rule changes.

1. **Consistency with Medicare.** CMS has historically allowed states to financially support GME programs through both direct and indirect cost reimbursement methodologies. This is a beneficial strategy to reduce manpower shortages and is consistent with authority under Medicare.
2. **Discretion to the states.** Medicaid is a federal/state partnership that allows states discretion in establishing service and program reimbursement methodologies consistent with program goals and that assures maintenance of effort within budget neutrality targets. GME falls within this discretionary authority.
3. **Meeting Federal requirements.** Federal requirements for state Medicaid programs include access to care and cost effectiveness. GME programs enhance service capacity and cost savings through physician residents at teaching hospitals and ambulatory care clinics assuring the state's supply chain of future providers.
4. **Provider shortages increase costs.** The Medicaid program has grown, increasing the demand for primary and specialty medical care. It is antithetical to reduce financial support to a program like GME, which is critical to meet this growing demand. Moreover, it is well documented that provider shortages in public programs leads to higher emergency room and inpatient utilization by Medicaid beneficiaries.

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Medicaid GME funding has been recognized implicitly since the program's inception.

I disagree with the assertion that it is inconsistent with the Medicaid statute to pay for direct costs associated with GME. Arizona's utilization of Medicaid funds as a source of program revenue to finance GME is well-grounded. While there is, in fact, no statutory requirement for states to make GME payments, the Centers for Medicare and Medicaid Services (CMS) has recognized its implicit authority to make federal financial participation available for direct GME costs both in its rulemaking, as expressed in the current 42 C.F.R. §§ 438.6 and 438.60, and in its approval of Arizona's state plan amendments in 1993, 1998, and 2000.

Acting on approval by CMS, other states have made GME payments under their Medicaid programs since the beginning of the program. Medicaid payments for GME have been recognized and reviewed by the Office of Inspector General and the General Accountability Office. And despite this long history, Congress has never intervened to end CMS' authority to approve the use of Medicaid funds for GME program support.

Medicare's underlying policy rationale for GME is applicable to Medicaid today.

In addition, while the Medicaid statute does not explicitly authorize the expenditure of federal funds, the rationale for providing the express authority in Medicare also applies to Medicaid. In providing the explicit authority in Medicare, Congress was responding to general concerns that the nation was suffering from a shortage of physicians. Congress believed that educational activities contributed to the quality of care within institutions, and such activities were necessary to meet community needs for trained personnel. While it is true that Congress decided Medicare should only participate until communities shouldered the costs in some other fashion, Congress has not acted to substantially limit or eliminate Medicare subsidies for GME.

Arizona, as the nation's fastest growing state, is facing an imminent physician workforce crisis. Recently, researchers at the Arizona State University and the University of Arizona published the *Arizona Physician Workforce Study, Part I*, which found that Arizona had 20.7 physicians per 10,000 people – substantially below the national average of 28.3. The study also found a disturbing maldistribution of physicians, ranging from a high of 27.6 in urban Pima County to a low of 4.8 in rural Apache County.

Arizona is taking action to address this workforce crisis. With the recent opening of the joint University of Arizona-Arizona State University medical school in Phoenix, Arizona now has two allopathic and two osteopathic schools of medicine. Researchers have demonstrated that there are clear connections between locations of medical schools and residency training, and between residency training and initial practice locations. Simply put, states with a higher percentage of physician residents from in-state medical schools are more likely to retain in-state graduates for residency; likewise, states with a higher percentage of physician residents from in-state medical schools are more likely to retain physicians of all specialties in all geographic locations. Therefore, Arizona's expansion of in-state medical school capacity can expand Arizona's physician workforce, *but only if* Arizona has sufficient capacity of in-state graduate medical education programs to accept more in-state graduates. Medicaid GME funds are a critical tool

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for maintaining and expanding physician capacity. Medicaid, as a payer for 18% of all Arizonans, is a vital component of the healthcare fabric of this state.

GME programs add directly to the state's service capacity by providing clinical services to Medicaid beneficiaries. Additionally, GME programs train the next generation of providers, which assures not only future capacity but also providers who are up-to-date with the changes in evidence-based medicine and the access and quality of care requirements of public programs that have been part of their training program.

Address accountability concerns through regulation and guidance.

Reviewing the notice and proposed rule, it appears that CMS has significant concerns regarding accountability in the use of Medicaid GME funds. The notice asserts that traditional Medicaid financing of GME

assures Federal participation, but does not provide clear accountability. Funding intended by the States to support GME often becomes subsumed within MCO or hospital rates (including supplements to these rates) or inpatient disproportionate share hospital (DSH) payments. As a result, it is difficult to quantify Medicaid GME payments or monitor and measure the effect of Medicaid payments on GME programs,

72 Fed. Reg. 28930, 28932 (May 23, 2007). Although there are some challenges of accountability regarding the use of federal matching funds for GME, the solution is not to scrap the program altogether, removing billions of dollars from the nation's teaching hospitals and medical education training programs. Rather, steps should be taken at the federal level to link Medicaid GME financing to the achievement of specific workforce objectives while continuing to provide states with flexibility to demonstrate innovative ways to meet those objectives.

As an example, by linking GME funding to the achievement of the state's workforce objectives, and to serving Medicaid-eligible persons, Arizona is holding teaching programs – and itself – more accountable for the use of GME funds. Traditionally, Arizona has modeled Medicaid GME payments after Medicare's payments, providing no restriction on specialties of physicians being trained and providing little assistance to cover the costs of training physicians in rural and non-hospital settings. Recently, however, Arizona has altered its Medicaid GME program to link payments directly to its workforce objectives.

In 2006, Arizona Governor Janet Napolitano secured an additional \$12 million for the expansion of existing residency programs and for the development of new residency programs. This year, Governor Napolitano requested an additional \$9 million in total funding for GME. The Governor's proposal explicitly links the new funding to the achievement of the state's physician workforce objectives by directing funds toward new teaching programs in rural counties, new residency positions that include rural county rotations, and to programs that encourage residents to establish permanent practices in rural counties. Programs receiving GME funding in either

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year, must identify and report the number of new residency positions created, including positions in rural areas.

Arizona goes beyond merely recognizing that financing physician training benefits all members of a community. In Arizona, explicit funding for GME is linked to the provision of services to Arizona's Medicaid members. AHCCCS has established a Memorandum of Understanding (MOU), voluntarily entered into between AHCCCS, a teaching program, and a Medicaid managed care organization. Upon entering into the MOU, AHCCCS and the Medicaid MCO work together to ensure that a sufficient number of Medicaid members are assigned to the teaching program to support that teaching program. Teaching programs in Arizona have as many as 7,000 assigned Medicaid members. In this way, GME funding directly benefits the many AHCCCS members who receive care at the teaching program. In turn, teaching programs provide educational opportunities for residents to familiarize themselves with principles of managed care and encourage residents to locate practices in Arizona.

With millions of dollars at stake, Arizona has a substantial interest in Medicaid GME funding. The abrupt and arbitrary elimination of this funding jeopardizes Arizona's efforts to address its workforce crisis, and the loss of funds will impact access to care, quality of care and preventive medicine at the very time that the President and Secretary are urging transparency and value driven health care decisions.

As a public servant, I share CMS' concerns regarding the accountability of public funds and take very seriously our fiduciary responsibility to taxpayers. It appears that due to these concerns, CMS wants to terminate GME funds putting at risk the ability of our state to build the physician workforce needed for the future. For these reasons, I respectfully request CMS to rethink this decision and work with its state partners to create the appropriate level of accountability necessary to maintain this vital program.

Sincerely,



Anthony D. Rodgers
Director

Janez Napolitano, Governor
Anthony D. Rodgers, Director



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October 12, 2007

Kerry Weems
 Acting Administrator
 Centers for Medicare & Medicaid Services
 Department of Health and Human Services
 Attention CMS-2261-P
 P.O. Box 8018
 Baltimore, MD 21244-8018

Dear Mr. Weems:

As Director of the Arizona Health Care Cost Containment System (AHCCCS) I am pleased to submit comments on the proposed regulations regarding Medicaid Coverage for Rehabilitative Services, published at 72 Fed. Reg. 45201 (August 13, 2007). AHCCCS is the state agency that administers Arizona's Medicaid program, which covers over one million members.

The rehabilitative services option is the primary basis of Arizona's outpatient behavioral health services program. Some of the behavioral health services AHCCCS provides under the rehabilitation services option include screening, assessment, and evaluation; counseling, including individual, group, and family therapy; behavior management services, including peer support; psychosocial rehabilitation, including living skills training; and medication management. AHCCCS has elected to provide most physical, occupational, and speech and hearing services under the separate state plan option related to those services; therefore, these comments relate specifically to the coverage of behavioral health services.

Rehabilitative services are essential to help people with mental illness improve or maintain their functioning, allowing people with mental illness to reduce their dependence on inpatient services.

42 C.F.R. § 440.130(d)(1)(iii)

The proposed rule defines the term "qualified providers of rehabilitative services." It is unclear if this definition includes peer support services, which, as provided in State Medicaid Director Letter #07-011 "are an evidence-based mental health model of care" that "can be an important component in a State's delivery of effective treatment." AHCCCS recommends clarifying in the preamble to the final rule that peer support specialists can be qualified providers of behavioral health rehabilitative services.

42 C.F.R. § 440.130(d)(1)(iv)

The definition of "under the direction of" in the proposed rule requires that a licensed practitioner supervise the provision of physical therapy, occupational therapy, and services for individuals with speech, hearing and language disorders. While the proposed rule states that this definition applies specifically to providers of those services, the last sentence of the definition states that the "language is not meant to exclude appropriate supervision arrangements for other rehabilitative services." AHCCCS is concerned that this language will be construed as requiring comparable levels of supervision for behavioral health services. Arizona is experiencing a shortage of licensed behavioral health providers, and requiring a comparable level of supervision for behavioral health services would severely jeopardize the availability of behavioral health services; therefore, AHCCCS recommends that the last sentence of the definition be removed.

42 C.F.R. § 440.130(d)(1)(v)

The proposed rules define "rehabilitation plan" and introduce requirements for the written rehabilitation plan. The regulation is silent on the relationship between the rehabilitation plan and the treatment plan, and AHCCCS is

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concerned that the proposed rules will require two plans and two planning processes for the written rehabilitation plan and a separate treatment plan. AHCCCS recommends that the rules clarify that the treatment plan can be the written rehabilitation plan (as long as the treatment plan includes all requirements for the rehabilitation plan) rather than require two separate planning processes and plans.

42 C.F.R. § 440.130(d)(1)(vi)

The proposed regulation defines "restorative services"; however, it is unclear how the term will be used in the final rule because the term is not used in the proposed rule or the statute. The definition states that the "emphasis in covering rehabilitation services is on the ability to perform a function rather than to actually have performed the function in the past." AHCCCS is concerned that this definition may be used to exclude services for young children because the child's capacity to perform the function may not be known. AHCCCS is recommending that the proposed rules or the preamble clarify the application of this rule to young children who had not yet reached developmental milestones.

The proposed definition also states that "services provided primarily in order to maintain a level of functioning in the absence of a rehabilitation goal are not within the scope of rehabilitation services." It is unclear if this sentence allows the rehabilitation goal to be maintenance of function; however, maintenance of function is often an appropriate goal for individuals with behavioral health conditions. AHCCCS recommends that the regulations be written or applied in a manner consistent with the Medicare Hospital Manual § 230.5(B)(3) which provides: "For many other psychiatric patients, particularly those with long-term, chronic conditions, control of symptoms and maintenance of a functional level to avoid further deterioration or hospitalization is an acceptable expectation of improvement."

42 C.F.R. § 440.130(d)(3)(xi)

The proposed rule requires that the written rehabilitation plan "indicate the anticipated provider(s) of the service(s) and the extent to which the services may be available from alternate provider(s) of the same service." This is apparently included to ensure patients have a choice of providers; yet there are already several processes in place to ensure patient choice, including informed consent and the grievance and appeal process. Further, in the managed care setting, individuals are provided a comprehensive directory of network providers. Listing all providers in the rehabilitation plan is onerous and makes the rehabilitation plan unwieldy and can lead to a delay in accessing services.

42 C.F.R. § 440.130(d)(3)(xiv)

The proposed rule provides, "If it is determined that there has been no measurable reduction of disability and restoration of functional level, any new plan would need to pursue a different rehabilitation strategy including revision of the rehabilitative goals, services and/or methods." Consistent with the above comment regarding the definition of "restorative services," AHCCCS recommends that the regulation be written or applied in a manner consistent with Medicare.

The Medicare Hospital Manual § 230.5(B)(3) provides:

"The treatment must, at a minimum, be designed to reduce or control the patient's psychiatric symptoms so as to prevent relapse or hospitalization, and improve or maintain the patient's level of functioning.

"It is not necessary that a course of therapy have as its goal restoration of the patient to the level of functioning exhibited prior to the onset of the illness, although this may be appropriate for some patients. For many other psychiatric patients, particularly those with long-term, chronic conditions, control of symptoms and maintenance of a functional level to avoid further deterioration or hospitalization is an acceptable expectation of improvement. "Improvement" in this context is measured by comparing the effect of continuing treatment versus discontinuing it. Where there is a reasonable expectation that if treatment services were withdrawn the patient's condition would deteriorate, relapse further, or require hospitalization, this criterion is met."

"Some patients may undergo a course of treatment which increases their level of functioning, but then reach a point where further significant increase is not expected. Such claims are not automatically considered noncovered because conditions have stabilized, or because treatment is now primarily for the purpose of maintaining present level of functioning. Rather, coverage depends on whether the criteria discussed above are met. Services are noncovered only where the

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evidence clearly establishes that the criteria are not met; for example, that stability can be maintained without further treatment or with less intensive treatment."

42 C.F.R. § 440.130(d)(3)(xv)

The proposed rules require the rehabilitation plan to "document that the individual or representative participated in the development of the plan, signed the plan, and received a copy of the rehabilitation plan." This requirement can become a barrier to services for individuals who refuse to sign the form for reasons related to their disease or disability. For example, individuals who have been court-ordered to receive treatment may refuse to sign the form. Individuals with paranoid disorders or cognitive disabilities such as dementia, may refuse to sign because they do not understand. AHCCCS recommends that there be a means of opting out, if the reason for failing to obtain the individual's signature is included in the rehabilitation plan.

42 C.F.R. § 440.130(d)(3)(xvi)

The proposed regulation requires that the rehabilitation plan "document that the services have been determined to be rehabilitative services consistent with the regulatory definition." It seems unreasonable to require a clinician to document compliance with the proposed regulation, and including this makes the document more complex for both clinicians and individuals and their families. As required by 42 C.F.R. § 440.130(d)(3)(x), the document has already been signed by the individual responsible for developing the plan. Individuals may be even more uncomfortable signing the document. AHCCCS recommends deleting this provision.

42 C.F.R. § 440.130(d)(3)(xvii)

Under 42 C.F.R. § 440.130(d)(3)(i), the rehabilitation plan must "be based on a comprehensive assessment of an individual's rehabilitation needs including diagnoses and presence of a functional impairment in daily living." The requirement that the rehabilitation plan must "include the individual's relevant history, current medical findings, contraindications" essentially forces the rehabilitation plan to rewrite or duplicate the comprehensive assessment required by 42 C.F.R. § 440.130(d)(3)(i). This requirement contains unnecessary work and makes the document even larger and more confusing for the individual or their family. AHCCCS recommends deleting this provision.

42 C.F.R. § 441.45(a)(5)

The proposed rule requires the state to "ensure the State plan rehabilitative services . . . specifies the methodology under which rehabilitation providers are paid." In the past year, several states have been forced by CMS to abandon case rate or the bundled approach which is paying for services and pay for billing of services in 15 minute increments. This approach significantly increases the amount of time that clinicians must spend completing paperwork and thus reduces the amount of time available to spend with clients. AHCCCS recommends that CMS provide states with necessary flexibility in reimbursement.

42 C.F.R. § 441.45(b)(1)

This section prohibits federal financial participation (FFP) for services that are "intrinsic elements of programs other than Medicaid." While the rule provides a few examples of services that are believed to be intrinsic elements of other non-Medicaid programs, it fails to identify the criteria used to determine whether a service is an intrinsic element of another program. This vague standard provides no guidance to states trying to implement the proposed regulations. At the same time, it appears to provide great latitude to CMS and the Office of Inspector General in interpreting this standard. Further, this appears to run counter to the goals developed by the President's New Freedom Commission on Mental Health. The report establishes goal 2.3, "align relevant Federal programs to improve access and accountability for mental health services" and states that "States will have the flexibility to combine Federal, State, and local resources in creative, innovative, and more efficient ways, overcoming the bureaucratic boundaries between health care, employment supports, housing, and the criminal justice systems." The "intrinsic element" standard establishes a new bureaucratic boundary that will have a chilling effect on state's efforts. AHCCCS recommends deleting this entire portion of the proposed rule.

Thank you for this opportunity to comment on the proposed regulation.

Sincerely,

Anthony D. Rodgers,
Director

Janet Napolitano, Governor
Anthony D. Rodgers, Director



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October 29, 2007

Mr. Kerry Weems
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention CMS-2213-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Dear Mr. Weems:

As Director of the Arizona Health Care Cost Containment System (AHCCCS), I am pleased to submit comments on the proposed regulations regarding the clarification of outpatient clinic and hospital facility services and the upper payment limit (UPL), published at 72 Federal Register 55158 (September 28, 2007). AHCCCS is the state agency that administers Arizona's Medicaid program, which covers over one million members.

As written, the proposed rule could have an impact on Medicaid reimbursement for outpatient hospital services and would more narrowly define outpatient hospital services, restricting mandatory approaches to calculating UPL for outpatient and clinic services. As a result, hospitals could receive lower payments since some services would no longer be reimbursable as outpatient hospital services, nor would they be included in the calculation for outpatient hospital UPL or disproportionate hospital payments (DSH). Additionally, CMS proposes to reduce states' flexibility in calculating the UPL applicable to private clinic services, requiring the use of Medicare fee schedules as the limit rather than actual costs.

Definition of "Outpatient hospital services"

CMS proposes to clarify what is described as "current vague regulatory language" for outpatient hospital services. CMS has concerns that the current broad definition overlaps with other covered services, resulting in higher reimbursement for identical services than would otherwise be available under the State Plan.

The proposed rule would limit the scope of services by excluding: 1) any service not treated as outpatient hospital services under Medicare; 2) services not provided by the hospital facility; and 3) services covered elsewhere in the State Plan- examples provided include are school-based services, adult day health and rehabilitative services, and services paid for under a fee schedule.

Although states would be allowed to continue covering services excluded from the proposed narrow definition of outpatient hospital services, they would not be permitted to reimburse them as outpatient hospital services. Additionally, under current CMS policy, services excluded from the narrowed definition of outpatient hospital services would no longer be eligible for DSH reimbursement because they would not be considered costs incurred by a hospital.

CMS 2213-P
October 26, 2007

Definition of "Outpatient Hospital"

Under the proposed rule, services can only be included in the outpatient hospital UPL if they meet the proposed definition of "outpatient hospital services" and appear on the outpatient-specific cost report worksheets. The Medicare standard for outpatient hospital services is more specific, particularly with regards to the settings that would qualify. The Medicare criteria for "provider-based status" is a complicated standard. As a result, some hospitals that are claiming a facility fee would only be eligible to receive payments for the professional services, not the facility charges.

Additionally, the proposed rule requires that in order to qualify as outpatient services, the service must be "furnished by an outpatient hospital facility, including an entity that meets the standards for provider-based status as a department of an outpatient hospital set forth in §413.65 of this chapter." 72 Fed. Reg. 55165. As a point of clarification, the phrase "including" suggests there might be other types of outpatient hospital facilities that qualify for these services other than those with the provider-based status. The preamble only discusses hospitals, facilities on hospital campus, and facilities with provider-based status. If there are other types of facilities that qualify, the rule language should clarify the facilities or refer back to the ones discussed in the preamble. Secondly, the term "meets the standards for provider-based status" suggests that the State might have the discretion to make that determination even if the hospital has not made or received a written determination from Medicare. For administrative simplification and operational ease, the rule should clearly state that the "entity has been determined by CMS to have provider-based status" so that States can refer to the CMS determination.

Definition of "Clinic Upper Payment Limits"

The proposed rules go beyond requiring a comparison or limit to payments under "Medicare principles." Rather, they specify how the estimated Medicare payments are to be calculated, requiring a hospital by hospital calculation of the Medicaid payments using the Medicare CCRs as reported on the Medicare cost report. The rules dictate the specific section of the Medicare cost report that a state may use in calculating cost information for outpatient UPL, which may result in excluding Graduate Medical Education costs from the outpatient costs that a state can include.

For private clinics, states would be required to calculate UPL either by adopting reimbursement methodologies that pay a specified percentage, not greater than 100% for Medicare; or by demonstrating that in the aggregate, Medicaid fee schedule rates are less than what Medicare would pay based on a comparison by the CMS current Procedural Terminology Code. Under these requirements, states would not have the option of calculating the clinic UPL based on the clinic's actual costs since the Medicare outpatient fee schedule rates are much lower than costs.

Although Arizona has a waiver from the UPL requirements so long as our Fee-For-Service payments remain less than 5% of service expenditures, the rules should reiterate that UPL limitations do not apply to payments made through managed care entities. However, I urge you to reconsider the proposed changes to limiting Medicaid payments for outpatient hospital services. Thank you for this opportunity to comment on the proposed regulation.

Sincerely,



Thomas J. Beflach
Deputy Director