



TRIBAL CONSULTATION MEETING

October 18, 2017

9:00 a.m. – 12:00 p.m. (Arizona Time)

AHCCCS Administration, Gold and Salmon Conference Rooms, 801 E. Jefferson St.
Phoenix AZ 86034

Conference Bridge: 1-877-820-7831, Participant Passcode: 108903#

NOTIFICATION TO TRIBES:

Good Morning,

Please mark your calendars to attend the final 2017 quarterly AHCCCS Tribal Consultation meeting on **Wednesday, October 18, 2017** from 9:00 a.m. to 12:00 p.m. at the **AHCCCS Administrative Offices, 3rd floor Gold and Salmon Rooms, 701 E. Jefferson St., Phoenix, AZ 85034**. The draft agenda is attached.

If you plan to participate by phone, dial **1-877-820-7831** and enter participant code, **108903#**. **Please mute your phones but do not place your phones on hold as this will disrupt the meeting with music.** Meeting materials will be posted to the AHCCCS website by October 17th, the day before the meeting. Click on the following link to access the meeting materials:

<https://www.azahcccs.gov/AmericanIndians/TribalConsultation/meetings.html>.

Please inform me if leaders from your tribe will attend this meeting as it is AHCCCS practice to recognize tribal dignitaries. Don't hesitate to contact me if you have questions.

Thank you in advance for your participation in this important meeting.

Bonnie Talakte

Tribal Relations Liaison

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AHCCCS TRIBAL CONSULTATION MEETING AGENDA

With Tribal Leaders, Tribal Members, Indian Health Services, Tribal Health Programs Operated Under P.L. 93-638
and Urban Indian Health Programs

Date: October 18, 2017

Time: 9:00 a.m. – 12:00 p.m. (Phoenix Time)

Location: AHCCCS Administration, Gold & Salmon Conference Rooms, 801 E. Jefferson St., Phoenix, AZ 85034

Conference Call-In: **1-8977-820-7831**, Participant Passcode: **108903#**

TIME	TOPIC	Presenter
9:00 - 9:15 a.m.	Welcome.....	Thomas Betlach, AHCCCS Director
	Invocation.....	Rachel Conley, <i>AHCCCS Tribal ALTCS Supervisor</i>
	Introductions.....	Director Betlach
9:15 – 10:15 a.m.	AHCCCS Update <ul style="list-style-type: none"> • Federal Update • October 1, 2017 New Benefit Changes • SB 1092 	Director Betlach
10:15 - 10:35 a.m.	Serious Mental Illness (SMI) Eligibility Determination	Shelli Silver, <i>Assistant Director Division of Health Care Management Health Care Financial/Data</i>
10:35 - 10:45 a.m.	Waiver Update <ul style="list-style-type: none"> • Institution for Mental Disease-Substance Use Disorder • Traditional Healing 	Elizabeth Lorenz, <i>Assistant Director Office of Intergovernmental Relations</i>
10:45–11:00 a.m.	State Plan Amendment (SPA) Update <ul style="list-style-type: none"> • Fee-for-Service Rates • Other Amendments • Occupational Therapy-15 Day Limit 	Kyle Sawyer, <i>Intergovernmental Relations Specialist Office of Intergovernmental Relations</i>
11:00 – 11:15 a.m.	Fee for Service Pharmacy Benefit Manager (PBM) RFP	Suzanne Berman, <i>Pharmacy Director</i>
11:15 - 11:35 a.m.	<ol style="list-style-type: none"> 1. Federally Qualified Health Centers (FQHC) Workgroup Update 2. American Indian Medical Home (AIMH) Update 	Markay Adams, <i>Assistant Director Division of Fee for Service Management</i>
11:35 – 11:50 a.m.	Quality Strategy	Jakenna Lebsock, <i>Clinical Administrator DHCM, Clinical Quality Management</i>
11:55 - 12:00 p.m.	Wrap-Up/Adjourn	Director Betlach

MEETING ATTENDEES:

Tribes	<p><u>Navajo Nation:</u> Gen Holona, Theresa Galvan, Marie Keyonnie, Arcenio Charlton, Mike Belecki, Cherie Espinosa, Rosita Paddock, Travis Renville, Glorinda Segay, Michele Morris, Marie Keyonnie, Marie Begay, Mabel Charley, Antonio Ramirez, Vera John, Charlene Begay, Norman Begaye, Lucy Bancroft, Roland Todacheenie, Alutha Yellowhair</p> <p><u>Pascua Yaqui Tribe:</u> Reuben Howard, Rosa Rivera, Linda Guerrero</p> <p><u>Salt River Pima Maricopa Indian Community:</u> Chris Christie</p> <p><u>San Carlos Apache Tribe:</u> Brenda Schildt, Melinda White, Jonathan Kitcheyan, Ron Ritter, Vickie Began, David Reede, Isaiah Belknap, Rochelle Keefee, Jim Smith, Otisha Rushtin</p> <p><u>Tohono O’odham Nation:</u> Vivian Saunders, Rosemary Lopez, Sandra SixKiller, Jeremy Gulock</p>
I/T/Us	<p><u>Gila River Health Care:</u> Scott Gemberling</p> <p><u>Fort Defiance Indian Health Board:</u> Christine Becenti</p> <p><u>Navajo Area IHS:</u> Loretta Christensen</p> <p><u>Phoenix Indian Medical Center:</u> Doreen Pond, John Meeth, Cheryle King, Arikah McClary, Jennifer Begay</p> <p><u>Tuba City Regional Health Care Corporation:</u> Yolanda Burke</p> <p><u>Tucson Indian Health Service:</u> Dan Marino,</p> <p><u>Winslow Indian Health Care Corp.:</u> Alutha Yellowhair, Roderick Antone, Cecelia Jackson, Carol Chitwood; Shannon Chimerica, Jacqanna Kinlacheeny,</p>
Other	<p><u>Arizona Advisory Council on Indian Health Care:</u> Kim Russell</p> <p><u>Arizona Department of Economic Security:</u> Shawn Sellers</p> <p><u>Arizona State Legislature:</u> Eric Descheenie, Jamescita Peshlakai</p> <p><u>Centers for Medicare & Medicaid (CMS):</u> Lane Terwilliger</p> <p><u>InterTribal Council of Arizona:</u> Alida Montiel</p> <p><u>Mercy Maricopa Integrated Care (MMIC):</u> Faron Jack</p> <p><u>Native Connections:</u> Kendra Haag</p> <p><u>Native Health:</u> Walter Murillo</p> <p><u>Native Resource Development:</u> Jermiah Kanuho</p> <p><u>Veridus:</u> Jason Barrazo</p>
AHCCCS Representatives	<p>Thomas Betlach, Elizabeth Carpio, Elizabeth Lorenz, Bonnie Talakte, Markay Adams, Kyle Sawyer, Jacqueline DeGrow, Karen Grady, Natalie Roehl, Leslie Short, Jakenna Lebsock, Rachel Conley, Lindsey Irelan, Kristen Challacombe, Julia Paulus, Matt Devlin, Suzanne Berman, Shelli Silver, Albert Escobedo, Valerie Jones</p>

MEETING SUMMARY

All meeting materials and presentations can be found at the AHCCCS Tribal Consultation website:
<https://www.azahcccs.gov/AmericanIndians/TribalConsultation/meetings.html>

TOPICS	SUMMARY
<p><u>AHCCCS UPDATES</u></p> <p><u>Presenter:</u> Thomas Betlach, AHCCCS Director</p>	<p><u>AHCCCS Population:</u> From 2014-2016 AHCCCS grew as a program and saw significant growth as a result of restoration and expansion. During the more difficult budget times we see growth in enrollment. However, in 2017 the overall enrollment became relatively flat. Similarly, there was significant growth in the American Indian Health Program population starting in 2014 but has leveled out in 2017.</p> <p><u>Budget Update:</u> The emergency dental program was restored and the occupational therapy program was expanded. Both were implemented on October 1st. The 2019 budget request is up by \$90m in general funds which is the main funding source for state government and provides the match we need as an organization to draw down federal funds. The overall request was almost a billion dollars in total funds. A significant portion of the overall budget request, \$26m, is for a health insurance fee that the MCOs pay. That is an item that is subject to debate right now at the federal level. That significant piece of our budget is dependent on what happens at the federal level as it relates to the insurance fee. <u>Budget process:</u> On September 1st AHCCCS submitted the budget to the Governor’s office and the Joint Legislative Budget Committee for the coming fiscal year. The Governor’s office submits their budget to the Legislature in early January and the Legislature will debate it throughout the Spring and by March or April AHCCCS will have a budget for the next fiscal year.</p> <p><u>Questions, Answers, Comments, Responses:</u></p> <p>C: My comment is about the \$1000 dental cap. If the health facilities exceed the \$1000 cap, we should be able to exceed the cap with the uncompensated care system in place.</p> <p>R: We had in place an uncompensated care waiver for emergency dental services. The emergency dental provision that was provided is more comprehensive than what existed before providing opportunities for IHS facilities to receive compensation for services that in the past was not recognized. We feel this more than compensates for having the \$1000 cap in place. If tribal nations and tribal policy makers want to pursue lifting the cap legislatively, that’s a discussion that can be had at the state legislature. The dollar amount is so minimal that for AHCCCS to maintain infrastructure for the uncompensated care waiver, and the fact that we restored the dental benefits more comprehensively, doesn’t give us reason to pursue this further.</p> <p style="text-align: center;">∞</p> <p>C: 100% of healthcare for Native Americans is taken care of by the federal government. AHCCCS does not comprehend that the federal government has responsibility for healthcare for Native Americans.</p> <p>R: This is a very broad policy topic you’re raising. I do understand the compliance and reporting requirements we have with CMS and the funding that we pass through, the auditing requirements and the expectations from our federal partners. While there are 100% pass through opportunities as it relates to the Medicaid program, it still has to fit within the context of the policy constraints and the legal requirements we’re claiming for the Medicaid program. We need legal authority to pay for the 100% pass through for services rendered.</p> <p style="text-align: center;">∞</p> <p>Q: Just to clarify, legislative authority is needed to fully leverage the 100% FMAP which is afforded to Tribal 638’s and IHS health facilities?</p>

A: Yes, we need CMS authority to seek a waiver to provide compensation so we can provide 100% pass through for the benefits. I encourage you all to seek legislation that provides that type of benefit but recognize that we still have to get that authority from CMS. We'll be happy to offer any technical assistance.

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Q: I'm wondering what impact the Douglas v California ruling would have on adult dental services if tribal programs moved to FQHC status.

A: There was a ruling in California with regard to dental services and FQHC's. The decision was that states had to include some dental benefits in the array of services that an FQHC can provide but didn't address the issue of what the scope or range of services had to be. We do have a dental benefit that we feel we're in compliance with as indicated by the 9th circuit ruling. We do offer dental benefits through FQHC's.

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C: In my opinion, the \$1000 per member per month is not sufficient for anyone. I do understand the legislature's concern to not add additional state dollars for Medicaid services. You said you need legislative authority but you have federal authority to draw down 100% pass through and the uncompensated care waiver. We have not seen a letter to the tribes indicating that the uncompensated care waiver is defunct, that we no longer need it. There is federal law that says AI/ANs Medicaid individuals have 100% pass through. I don't understand why the state legislative authority is necessary when AHCCCS has federal authority.

R1: We received approval from CMS and the ability to have that language so we could draw down hundreds of millions of dollars during the time when we had to suspend enrollment for the childless adult population and terminate certain services. The uncompensated waiver was tied to those specific services and the per member per month (PMPM) calculation of what was paid out. All of those services have been restored. There is no PMPM that is calculated. We're not taking the language out of the waiver because we don't know what may happen in the future. It's important to have that language and ability. If you look at how it was implemented on a PMPM calculation tied to specific benefits there is no PMPM calculated anymore. The reason why we need state authority is we don't have the ability to offer an adult dental package. AHCCCS doesn't have the state authority to offer that. If there was a state mandate to offer those services at certain sites, we'd have to talk to CMS to see what type of vehicle might be available to provide the 100% pass through. That is the only legal path I see forward as to provide us with the state authority to seek that benefit at that site and then work with our federal partners to see if we can get compensation.

R2: Yes, we receive 100% pass through for American Indian Medicaid members who receive services through IHS/638 facilities. That does not happen when they go outside of that system. We have about a \$Billion a year program from which we pay for services for American Indian members. About \$600M of that goes to IHS/638 facilities which are able to receive the 100% pass through but about \$400M is outside of the IHS/638 system. That absolutely has general fund impact. When we get into the discussion of it being a population vs a facility based benefit, the waiver we go to CMS with to request has to be very specific. We can't simply say 100% pass through when we know that IHS/638 facilities can't offer every service, especially specialty care, to AHCCCS tribal members who then have to go outside of those facilities to access that care. Not every facility is able to get 100% pass through.

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Q: If CMS gave approval for tribes to receive 100% pass through, are you saying that AHCCCS would still not be able to administer accordingly without legislative approval or are you saying you don't have the administrative/executive where-with-all to be responsive to

CMS? You would still need a law passed allowing that to happen?

A: Yes, it's a 2-step process. We'd need a state law to seek the authority from CMS to give us the ability to ask for federal reimbursement for services rendered and we need the authority from CMS.

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Q: What if CMS said go ahead and give it? The state would still not be able to do that?

A: If it is tied to a benefit, we don't have the ability to cover that benefit right now.

Graham Cassidy Proposal: The Graham Cassidy proposal builds off of the previous Senate version of Repeal & Replace called BCRA. It includes per capita caps which is an underlying methodology that limits the federal contribution for the Medicaid Program going forward. It combines Medicaid expansion dollars, tax credit and cost sharing funds into a block grant. For the State of Arizona, that's about \$4B that is included in those 3 different funding streams. It provided, similar to the BCRA, 100% federal financing for all American Indians services. The senate bill would have made that 100% participation. It would have allowed American Indians to stay in a Medicaid expansion program which we felt was important in AZ. The start date was scheduled for January 1, 2020 which was an aggressive start date. It created a list of what the block grant could be used for including; high risk pools, funding to insurers to stabilize premiums, pay providers directly, pay individuals for out of pocket costs, provide coverage through Medicaid (limited) and coverage through managed care. There were different types of flexibilities.

Q: What happens, in a block grant environment, with the role of CMS?

A: In looking at the Graham Cassidy proposal, CMS did not have a significant role. It was largely up to the states to determine their program based on the wide list of issues. With American Indian's there is still opportunity of a state option to keep them in a Medicaid program. It would be the same as it is today. That didn't change. Under the Graham Cassidy, as it relates to the block grant, CMS had little oversight role but states had broad authority on how to establish their programs.

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C: In reviewing the Sanders-Alexander bill. I don't see any of this in there. Block grants were not in there. It revolves around the waiver giving states a lot of flexibility in what they want to do locally. If there are issues such as expanded dental there is opportunity for your policy people to make that case with state support.

R: When looking at the by-partisan agreement in the Senate it has nothing to do with Medicaid. What the President said is he was no longer going to pay what is known as the cost sharing subsidies. That's a Market place responsibility. The Market has 2 pieces-tax credit and cost sharing subsidies. There was no appropriation for cost sharing. The White House said they were not going to pay it. Congress has come back with this tentative bi-partisan agreement. We'll have to wait to see what is going to happen, what the House Freedom Caucus says and others. The Repeal & Replace discussion is not over.

CHIP/KidsCare Funding: Another area of uncertainty is the CHIP Program or Kids Care. We saw the program restored a couple of years ago and have seen the enrolment grow over the last year and a half from less than a 1,000 individuals to approaching 25,000. CHIP is paid for 100% by the federal government for all CHIP members. Congress needs to re-authorize the funding. We have enough money to get us through December. CMS is allocating money to several states to get us through until we see what Congress does. As it stands right now we'll get 23% for this federal fiscal year and next. The year after that it steps down to 11.5% and the 4th year it goes back to the traditional level of 75%. State law says that if the federal match rate drops below 100% we are to freeze the program. If the Federal Legislation passes as it stands now, that gives our state legislators, this session and

next session, time to determine what to do with KidsCare in AZ.

Q: Have you worked out the numbers yet if the Feds go back to 75%? That means the state needs to come up with 25% to keep KidsCare intact and if the 25% is the difference the state needs to come up with to house the KidsCare program?

A: If the federal government rolls back the FMAP we have something in our own statutes that triggers the freeze. It's not about coming up with the difference we have to freeze the program. To unfreeze it we have to come up with the state match. That state match is broader than the KidsCare Program. You've also got the state Medicaid expansion piece which gets impacted by this. Its two pieces for \$40M.

AHCCCS Complete Care Timeline: In the next 14 days we will be releasing our RFP for the AHCCCS Complete Care Program which is our integrated care product for adults and kids in our system. American Indian's will continue to have choice of Fee for Service vs an AHCCCS Complete Care contract. There is no lock-in period. American Indian's will retain a choice of providers. If you are part of a managed care plan you can still go to any IHS facility. If you are part of the AIHP program you can go to any AHCCCS registered provider. We have been releasing major decisions about the RFP as it relates to the integrated aspects of it. Check the website for the major decisions.

Waiver Update – SB 1092: We have not submitted the Waiver request yet as it relates to the work requirement. That is a mandate that we have to submit that was due in March. That date has come and gone. We have been going through the significant 500 stakeholder comments with the Governor's office. We also wanted to wait and see what happened with Repeal and Replace. If there was a block grant decision, some form of a Waver isn't necessary at that point. It's up to the state to establish those requirements. We have said publically that we'd like to submit to CMS to fulfill the statutory requirement by the end of this calendar year.

Q: Do you have any feel of where that is and when a decision will be made?

A: Several states have submitted but nothing has been approved yet. There are discussions all across the Department and with our other Federal partners about the requirement and how it will affect Medicaid.

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Q: if CMS would move forward and approve a state, how quickly might other states move forward?

A: All demonstration applications are unique and individual. While they are all individual and individually assessed by our federal partners and within CMS, they are precedent setting.

Q: Are there going to be exemptions for the tribes?

A: I cannot speak to the specific exemptions that may be included in the package. We have taken all the comments in and have had discussions both internally and with the Governor's office. We continue to have conversations around all of that.

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C: Tribal consultation should be done with each tribe and on their respective lands.

R: We try to get out to tribal lands as often as we can. If any tribe wants to host a consultation meeting in 2018 we would be happy to do that. Staff and Director Betlach have made it out to San Carlos Apache Tribal lands at least 3 or 4 times. We would like the opportunity to visit your tribe when invited.

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Q: Can you explain the nature of the concept paper?

A: The concept paper is in response to a letter sent to AHCCCS from then Secretary Price

	<p>and Administrator Verma that says, “States”; we are open to new flexibilities. The concept paper is to engage with our federal partners on some specific issues in which they indicated they are interested in seeing what flexibility they can provide the states and we’d like to find out they can provide around flexibility.</p> <p style="text-align: center;">∞</p> <p>Q: What other groups have been talking to you around exemptions for their populations? What other stakeholder groups have approached AHCCCS and the Governor’s office to exempt them that aren’t already included in statute?</p> <p>A: I’d be doing a lot of disservice to the answer without taking a look at the 500 comments that we received that highlight groups and circumstances. I wouldn’t refer to a group but to the circumstances. We have posted the comments to the website. There was very little public comment on this legislation going through this process.</p> <p>Q: If the work requirement passes, has there been an analysis done on what the States’ investment might be?</p> <p>A: What we have been looking at over the past months have been the operational implications. We’re working through the operation ramifications.</p> <p><u>Analysis of CMDP Integration:</u> We are doing an analysis and working with consultants to see what type of lift it would take to integrate all of the services within CMDP. It will require some legislative funding if we are to move toward an integrated structure at DCS.</p> <p><u>Hospital Assessment Update – IHS Exempt:</u> IHS and tribal 638 facilities are exempt from the hospital assessment that has been put in place to fund the restoration expansion. However, there is ongoing litigation over the assessment. The Supreme Court is hearing the case this month. It is around whether or not the assessment is constitutional in the way that it was past with a simple majority.</p> <p><u>Publish Parity Analysis:</u> AHCCCS has to publish a parity analysis between physical health & behavioral health benefits to ensure there is parity. We will publish the analysis this quarter.</p> <p><u>Staffing Transitions:</u> Current Deputy Director, Beth Kohler will be leaving the agency in November. Jamie Snyder has been hired as the new Deputy Director. Jamie was the Director of the Texas Medicaid program.</p>
<p><u>SERIOUS MENTAL ILLNESS (SMI) ELIGIBILITY DETERMINATION CONTRACTORS RFP</u></p> <p><u>Presenter:</u> Shelli Silver, Assistant Director, DHCM, Health Care Financial/Data</p>	<p><u>Purpose:</u> The RFP will serve as a statewide contractor to conduct eligibility determinations for those who may have a serious mental illness (SMI). The determinations are made for persons who are 18 years and older, for persons 17 years and 6 months who are currently receiving behavioral health services and for persons ordered to undergo a determination by the Superior Court in Arizona.</p> <p><u>Overview of Requirements:</u></p> <ul style="list-style-type: none"> • The effective and efficient identification of persons who have special behavioral service needs • A standardized process and criteria to determine SMI eligibility • A behavioral health assessment that determines if the individual meets SMI eligibility including the use of treatment records to make a final determination. • The Contractor will be responsible for rendering final SMI eligibility determinations, the grievance system requirements and all administrative responsibilities • The Contractor must develop and maintain a quality management program and information systems • Must adhere to key personnel requirements • Serve as a statewide contractor

Current Landscape: The current contract ends 12/31/18. Recent changes impacting the current contractor include; Administrative Simplification - the merger with DBHS makes this the first time the RFP is under AHCCCS, service expansion for Fee-for-Service, Tribal ALTCS, and ALTCS E/PD. The AHCCCS Complete Care RFP is underway for integrated physical and behavioral health services for most members.

Procurement Timeline:

- March 15, 2018 – Issue Request for Proposal
- March 26, 2018 – RFP Questions Due from Prospective Offerors by 5:00 p.m. AZ time
- April 2, 2018 – First RFP Amendment Including Responses to RFP Questions
- May 10, 2018 – Proposals Due by 3:00 p.m. AZ Time
- July 2, 2018 – Contract Awarded
- January 1, 2019 – Implementation
- Through September 30, 2023 – Term of Contract

Stakeholder Feedback: AHCCCS is interested in feedback and any concerns or questions tribal stakeholders may have with the RFP. Questions and comments can be sent to SMIEligDet_RFP_Feedback@azahcccs.gov. Comments and feedback will be accepted until close of business, November 23, 2017. Examples of questions that stakeholders may have are:

- How can the SMI eligibility determination process be improved for applicants?
- How can the SMI eligibility determination process be improved for providers?
- Requirements regarding education and training for Tribal ALTCS, FFS, MCOs, and Providers
- SMI eligibility grievance and appeal processes
- Tribal Liaison collaboration
- Collaboration with HIS/638 facilities
- Coordination with Justice systems
- Exchange of behavioral health assessment
 - What is working? What could be improved?
 - Should this be an AHCCCS product and not a vendor product?
- Exchange of determination decision via the AHCCCS SMI portal

C: I'd like to see some data with regard to the number of referrals that have been made for SMI designation by tribes, how many were successful, how many were denied, how many appealed.

R1: In the SMI determination process, it's a multi-step process. We have done a lot of improvement between AHCCCS and the contract with the Crisis Response Network (CRN), the statewide vendor responsible for completing SMI determinations. We agree, in the initial assessment, that it's our tribal stakeholders and tribal providers that are closest to the member. They can initiate and start the assessment process. After the initial assessment is made the referral packet goes to CRN. CRN will review it and if it is headed toward denial the tribal liaison and clinician will meet with the clinical team that's closest to the member to explore if there are other circumstances that aren't reflected in the documentation. Additionally, prior to the individual process, the tribal liaison and CRN will meet with the individual tribes whether its TRBHA or tribal ALTCS to see if there are cultural adaptations or clinical perspectives that should be taken into account.

R2: I'm not sure how much AHCCCS can drill down specifically by tribe because people don't necessarily have to provide that information, it's voluntary. We'll have a staff member follow up on your request to see how close we can get and provide the information you're looking for.

	<p>C: I'm more concerned about the denials.</p> <p>R: For the denial reasons, we'll be able to look at it as an aggregate. But we may run into HIPPA concerns. We should be able to potentially look to able to get some of that information.</p> <p style="text-align: center;">∞</p> <p>C: What is the rational for the RFP? What's the benefit?</p> <p>R: Prior to the current vendor starting a number of years ago, the RBHAs themselves made the SMI determinations. There is a payment rate differential from AHCCCS to the RBHA for a member with SMI vs a member without SMI. It is significantly higher when a member has SMI. There was a concern whether the determinations were appropriate. It was determined that it would be best to have an independent party make the determinations which then would drive the AHCCCS payments to the RBHA'S. There were denials when the RBHAs did the determination. The denials would be based on the clinical decision and on the documentation of the Providers' assessment that the member did not meet the criteria that has been established. Every AHCCCS member is entitled to behavioral health services to whatever extent is medically necessary.</p> <p style="text-align: center;">∞</p> <p>C: I have one recommendation. The Navajo Nation is working on a project. Navajo Nation is dealing with 3 state Medicaid programs, Utah, New Mexico and Arizona. One thing we've always heard in managed care in New Mexico is health assessment overkill. Because were doing some integration between all 3 Medicaid programs I request that you look at commonalities in some of the SMI determination assessments in Utah and New Mexico. That would really help us with our project.</p> <p>R: I will make note of that.</p> <p style="text-align: center;">∞</p> <p>C: I'm not sure if tribes are facing this as well as far as opt in and opt out purposes. One thing we've come across is having acute hospitals accept diagnosis and evaluations. In addition, slide 2 makes mention of Superior Courts. Early in the year, the Navajo Nation hosted a public safety summit. We had all the tribal judges there and talked about individuals being voluntarily committed. I don't see on the slide that AHCCCS is working with tribal courts. You can't leave our tribal courts out of the discussion.</p> <p>R: Thank you for your comments.</p>
<p>WAIVER UPDATE:</p> <p><u>Presenter:</u> Elizabeth Lorenz, Assistant Director, Office of Intergovernmental Relations</p>	<p><u>What is an IMD?</u> An institution of more than 16 beds that is primarily engaged in the care and treatment of individuals with mental diseases, whether or not it is licensed as such. Examples: psychiatric hospital, nursing facility, residential treatment center. A psychiatric unit of a general hospital is not an IMD.</p> <p><u>CMS's New Managed Care Rule:</u> Managed care regulations issued July 5, 2016, prohibit federal funding for stays in IMDs if the stay is more than 15 days in a calendar month. This applies to adults aged 21-64. It effectively restricts Arizona's "in lieu of" authority so that stays in IMDs in lieu of more expensive settings are not reimbursed by the federal government if the stay exceeds 15 days.</p> <p><u>Effects of CMS's Managed Care Rule:</u> If a member's stay in IMD is more than 15 days, the State must recoup the entire monthly capitation payment from the MCO for that member. AHCCCS can then reimburse the MCO for the number of days in that month in which the member was NOT in an IMD (if any). Regardless of recoupment, the member is still enrolled with a plan, the plan is still responsible for care, and the MCO must pay providers for medically necessary services. Challenges include developing an adequate network of non-IMD alternatives and the higher cost of alternatives.</p> <p><u>Waiver Update: Institutions for Mental Diseases:</u> On April 12, AHCCCS submitted a waiver</p>

	<p>requesting that Arizona be exempt from the 15 day limit on federal funding for IMD stays, both for managed care and FFS population. On October 6, CMS approved West Virginia’s request (as part of a larger waiver application from 2016) to exempt substance use disorder stays in IMDs from the 15 day limit. AHCCCS expects to hear from CMS soon about applying this exemption in Arizona.</p> <p><u>Traditional Healing:</u> AHCCCS is seeking authority to reimburse for Traditional Healing services as a covered service and is awaiting CMS guidance on pursuing a SPA vs Waiver.</p> <p>Q: Is the traditional healing program member centric or provider reimbursement centric? A1: This is different program than New Mexico. We’re trying to make Traditional Healing a covered Medicaid service. We’re working to get 100% FMAP reimbursement. It’s taking time to work through all the details with CMS. A2: It would not be member payments but facility based payments.</p> <p style="text-align: center;">∞</p> <p>Q: For bullet point #2, what date was the current draft submitted to CMS? A: I have to look up the date. It was couple of months ago.</p> <p style="text-align: center;">∞</p> <p>Q: In regard to IMD’s, in the instance of an American Indian enrolled in AIHP, who is not enrolled in an MCO, how does this impact them? A: There is no impact on FFS members. We have identified a path forward to not use federal dollars because the numbers are small enough of American Indian members receiving services though IMD’s. We identified alternative funding dollars. We were restricted in using federal dollars to support those services.</p> <p style="text-align: center;">∞</p> <p>Q: Is that sustainable without federal dollars? A: This is part of the reason why we’re seeking authority to have our FFS members included in the IMD waiver. It would be beneficial to have an across the board benefit for that population. As far as sustainability, it very small numbers at this point we don’t see an issue with it. We’re monitoring it.</p>
<p><u>STATE PLAN AMENDMENT UPDATES</u></p> <p><u>Presenter:</u> Kyle Sawyer, Intergovernmental Relations Specialist and State Plan Specialist</p>	<p><u>Annual Rate Changes:</u> Several rate changes were made on October 1st. These include:</p> <ul style="list-style-type: none"> • Physician drugs updated for 4.8% aggregate increase • CON Ambulance rates increase 2.7% • FFS Ambulance increase 3.3% • LTAC and Rehab increase .5% • Outpatient BH increase .1% <p><u>Value Based Purchasing (VBP):</u> VBP is now referred to as Differential Adjusted Payments (DAP). AHCCCS will be issuing the following DAP payments:</p> <ul style="list-style-type: none"> • Inpatient hospitals and facilities that participate in the Health Information Exchange (HIE) will be eligible to receive a 0.5% increase in inpatient and outpatient rates. • Integrated Clinics certified by ADHS as an integrated clinic and provide 40% of behavioral health services will be eligible to receive a 10% increase on select FFS codes. • Nursing Facilities that exceed the statewide average pneumococcal and influenza vaccines will receive a 1% increase for each variable. • <i>NEW</i> - Physicians, Physician Assistants and Nurse Practitioners with over 100 prescriptions to AHCCCS member s and over 50% are E-prescriptions will receive a 1% increase. <p><u>Emergency Dental & Occupational Therapy:</u> As was discussed earlier, Senate Bill 1527 was passed this past legislative session. Also covered by the bill, as a covered service, was Outpatient Occupational Therapy. AHCCCS limited the visits to 15 visits for rehab and 15</p>

	<p>visits for habilitation. Another covered service is Emergency Dental Care and extractions up to \$1000. The effective date for these services is 10/1/17.</p> <p><u>Share of Cost:</u> AHCCCS will be submitting a SPA to expand the scope of share of cost deductions to include medical services not reimbursed under the state plan. AHCCCS will submit reasonable restrictions on the claiming of these deductions.</p> <p><u>KidsCare Mental Health Parity:</u> All states will be submitting SPAs to ensure compliance with federal mental health parity standards. KidsCare is deemed compliant by providing EPSDT services to children.</p> <p>Q: On the occupational therapies, is that per member per month? A: It is per member per year.</p> <p style="text-align: center;">∞</p> <p>Q: Looking at the rate increase for hospitals that participate in HIE, will there be assistance for hospitals that are still on RPMS to help with the transfer to HIE? A: The VBP does not apply to IHS/638 facilities. You are not subject to the fee schedule. The reason we bring this to tribal consultation is because for any SPA that we submit regardless if it has a direct impact, or not, on an IHS/638 facility, our members go outside of that facility so we are required to bring it to tribal consultation so our tribes are properly informed as to what the health care system is doing for our members. For American Indian Medical Home hospitals that get connected to HIE, there is an additional rate increase.</p> <p style="text-align: center;">∞</p> <p>Q: In regard to the CON ambulance rates. Are tribes included in the rates? What guides the rate changes every year? A: Yes, tribes are included in the Fee-for-Service ambulance rates. The ambulance fee schedule is driven by state statute and DHS and their CON process. In addition to that, we did a 15% rate increase last year for FFS providers that do not fall under the CON process. The CON ambulance rate increase of 2.7% is a reflection of the CON process that has a built-in rate adjuster. We also did an adjuster for non-CON which is the same percentage.</p> <p style="text-align: center;">∞</p> <p>Q: Do those rate changes occur by policy? So another rate change can happen a year from now? A: The FFS ambulance policy change is the result of a policy change that came out of the workgroup. If there is a basis by which costs are going up and a rate adjustment is needed to meet access, which is the requirement for us to do rate adjustments.</p>
<p><u>PHARMACY UPDATE:</u></p> <p><u>Presenter:</u> Suzanne Berman, Pharmacy Director</p>	<p><u>Background</u></p> <p>The governor issued an executive order in early January to limit the initial supply of an opioid medication to 7 days for all AHCCCS members and state employees. Prior to operationalizing the Governor’s executive order, AHCCCS and its Contractors began requiring prior authorization for all long-acting opioid prescriptions on January 1, 2017. Our concentration efforts for the executive order were on short acting opioids. We implemented the 7 day limitation on April 1, 2017.</p> <ul style="list-style-type: none"> • The child and adolescent population is limited to a 7-day supply of short-acting opioids unless the member’s condition meets an exception. • Adults are limited to a 7-day supply of a short-acting opioid if they have not had a short-acting opioid in the last 60 days, unless the member’s condition meets an exception. If they have had an opioid in the past 60 days, then the prescription is not limited to the 7-day supply. • The 7-day supply of short-acting opioid requirements became effective April 1, 2017. • Exceptions <ul style="list-style-type: none"> ○ Active oncology diagnosis,

- Hospice care,
- End-of-life care (other than hospice),
- Palliative care,
- Children on opioid wean at time of hospital discharge,
- Skilled nursing facility care,
- Traumatic injury, excluding post-surgical procedures, and
- Post-surgical procedures

The Governor's executive order was not implemented for AIHP. We are not able to electronically operationalize the requirements because the member's entire profile is not in one system.

In early September, the Arizona Department of Health Services released the Opioid Action Plan which can be found on their website. The goals to address the opioid epidemic include:

- Increasing patient and public awareness to help prevent opioid use disorders
- Improve prescribing and dispensing practices;
- Reduce illicit acquisition and diversion of opioids
- Improve access to substance use disorder treatment; and
- Reduce deaths related to opioids.

Some of the plan's recommendations include:

- Limiting opioid prescriptions to a 5-day supply;
- Limiting the maximum Morphine Equivalent Daily Dose (MEDD) to 90. This means that if the patient's opioid prescription(s) dose(s) were converted to an equivalent dose of morphine, the maximum dose recommended is to be 90 mg per day or less; and
- Require all controlled substances be E-prescribed.

For the above recommendations AHCCCS is changing the current 7-day supply limitation on short acting opioids to a 5-day supply limitation beginning January 1, 2018. Currently, this change will only apply to MCO contractors. The Morphine Equivalent Daily Dose of 90 and the E-prescribing of controlled substance recommendations is currently under review at AHCCCS. More information will be provided at a later date.

The AHCCCS Medical Policy Manual Pharmacy Policy 310-V is in the process of being updated and will be posted on the website for comment towards the end of November. All of the exceptions currently listed in the AMPM Policy 310-V will remain the same. The 5-day limit of short-acting opioids will not be implemented for AIHP.

Arizona Department of Health Services Opioid Recommendations
Pharmacy & Therapeutics Committee Meeting Update:

The AHCCCS Pharmacy and Therapeutics Committee met on Thursday October 12, 2017. Several classes were reviewed with two major changes, one to the Hepatitis C class and the other to the Long Acting Opioid class.

Hepatitis C: The Committee recommended Mavyret to be the preferred agent to treat Hepatitis C effective on January 1, 2018. Mavyret can be used to treat all genotypes of the virus, the treatment is generally from 8-12 weeks and the outcomes from ABBVIE's clinical trials were excellent. Please refer to the package insert for specific treatment timelines. The Committee also recommended the fibrosis level requirements in the AHCCCS Hepatitis C prior authorization criteria be removed from the criteria. In addition, the committee recommended grandfathering members that begin treatment with a currently preferred direct acting antiviral prior to January 1st so that they can complete the specific drug regimen. AHCCCS is in agreement with these recommendations and they are effective January 1, 2018.

The committee also reviewed the long-acting opioid class and made the recommendation

to remove Oxycontin from the AHCCCS Drug List and add Xtampza, which is also a long-acting oxycodone product. Xtampza, when crushed becomes a very thick gel and cannot be snorted or injected. The effective date for these changes is January 1, 2018.

A memo to the MCO Contractors with all of the P&T changes will be available in approximately ten days, on the AHCCCS website under Pharmacy, under Pharmacy & Therapeutics and then under the meeting date of October 12th.

There have been significant discussions during the stakeholder meetings on the benefits of moving these processes to the FFS PBM, which include safety, having the member's entire profile in one system, online eligibility verification, timely payment and improved efficiencies for both AHCCCS and IHS/638 pharmacies.

FFS Pharmacy Benefits Manager (PBM) RFP: Prior to working on the PBM RFP, there were 3 stakeholder meetings with the IHS and 638 pharmacists and the discussions have been focused on 2 areas for claims billing. These billing process changes have to be approved by CMS.

- The billing of IHS/638 pharmacy prescription claims for the All Inclusive Rate, at the point of sale through the FFS PBM; and
- The billing of specific specialty drugs at the point of sale through the FFS PBM at the federal supply schedule acquisition cost plus a professional fee (also known as the dispensing fee).

The PBM RFP is expected to be released by the end of the year and the implementation date for the awarded contractor is 10/1/2018. As the process moves along, additional stakeholder meetings will be scheduled.

- All of the exceptions are listed in the AHCCCS Medical Policy Manual Chapter 310-V Prescription Medications - Pharmacy Services.

We sincerely appreciate the opportunity to meet and collaborate with the IHS and 638 pharmacists including the feedback that has been provided and the sharing of information across all stakeholders.

Q: When will the RFP come out?

A: We are targeting the end of December 2018. The actual implementation date is for the new contractor is October 1, 2018.

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Q: Were IHS & tribal 638's part of the P&T Committee? Did they provide recommendations about the changes on opioid short and long term prescriptions restrictions?

A: The people that serve on the P&T Committee have to submit application and there is a random selection process. There is a specific space for tribal IHS and 638 facilities on the committee. We are getting ready to contact new members. There are multiple opportunities for people to serve.

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Q: How are the oncology drugs being looked at as part of this?

A: We met with all the stakeholders and we looked at all the specialty drugs which includes oncology and it will have to be updated as we move forward.

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Q: With the changes in Oxycodone, how is that going to be messaged throughout the state of Arizona? Is there going to be marketing campaign?

A: We've already done the 7 day limit. We will continue our normal outreach efforts as it relates to educating physicians. The exemptions now will exist in the future. As part of the 10/1/18 procurement if we were going to make additional changes where we would include IHS facilities in those limits, there will be a policy that will go to tribal consultation and tribal input as part of that process.

<p><u>FEDERALLY QUALIFIED HEALTH CENTERS (FQHC) WORKGROUP & AMERICAN INDIAN MEDICAL HOME (AMIH) UPDATES</u></p> <p><u>Presenter:</u> Markay Adams, Assistant Director, Division of Fee for Service Management</p>	<p><u>Purpose of 638 FQHC Workgroup:</u></p> <ul style="list-style-type: none"> • Review the guidance issued by CMS, SHO #16-002 (Feb. 26, 2016) & FAQs (Jan. 18, 2017) expand federal funding for services received by AI/AN Medicaid beneficiaries as it relates to 638 facilities. • Provide AHCCCS with more in-depth tribal perspectives as it relates to the 638 FQHC issues. • Gather any specific questions the stakeholders may have and take back for research. • Identify how AHCCCS can operationalize the issues raised by the guidance as it relates to 638 facilities. <p><u>AHCCCS Draft Timeline:</u></p> <ol style="list-style-type: none"> 1. Workgroup meetings - 10/23/17 2. Tribal Consultation SPA Decision – January 2018 3. Start work with 638 Clinics that Opt-in to be FQHC – February 2018 <p><u>What is American Medical Home (AIMH):</u> Received authority to operationalize from CMS in spring 2017. American Indian/Alaska Native AHCCCS members enrolled in the American Indian Health Program (AIHP) can voluntarily be assigned to an IHS/638 facility for primary care case management and have 24 hour nurse call line.</p> <p><u>Eligible IHS/638 Provider Types</u></p> <p>02- Hospital 05 – Clinic (excluding Dental Providers) IC – Integrated Clinic C2 – Federally Qualified Health Center (FQHC) 29 – Community/Rural Health Center (RHC)</p> <p><u>AIMH Initial Application – Oct 1, 2017</u></p> <ol style="list-style-type: none"> 1. May take time for approval/signatures 2. Choose Tier level. Submit Fax, Email, US mail, hand deliver 3. Allow at least 5 days for DFSM review. 4. Health Plan ID assignment and set up for PM/PM EFT transfer. Allow 15-20 days 5. Voluntary AIHP members can now join the medical home. AIMH provider to use AHCCCS Online Portal or Member may contact the Division of Member Services- <p>Q: How many applications have you received from facilities A: We have received zero applications thus far.</p>
<p><u>QUALITY STRATEGY:</u></p> <p><u>Presenter:</u> Jakenna Lebsack, Clinical Administrator, DHCM Clinical Quality Management</p>	<p><u>Due to lack of time, this presentation will be moved to the January 11, 2018 Tribal Consultation meeting agenda.</u></p>
<p>Adjourn</p>	<p>Meeting was adjourned at 12:00 p.m.</p>