

November 26, 2018

Ms. Andrea Casart
Technical Director, Division of State Demonstrations,
Center for Medicaid & CHIP Services
7500 Security Boulevard,
Baltimore, MD 21244-1850

RE: Arizona's 1115 Waiver: AHCCCS Complete Care Technical Clarification

Dear Ms. Casart:

The Arizona Health Care Cost Containment System (AHCCCS) hereby submits a formal request to amend Arizona's Section 1115 Research and Demonstration Waiver. AHCCCS proposes technical amendments to the language of the Special Terms and Conditions to reflect the delivery system changes that resulted from the AHCCCS Complete Care (ACC) managed care contract award.

On October 1, 2018, AHCCCS transitioned 1.5 million AHCCCS members into managed care plans called AHCCCS Complete Care (ACC) plans that provide integrated physical and behavioral health care services. Specifically, the ACC Plans serve AHCCCS Acute Care Program enrollees except for adults determined to have a Serious Mental Illness and foster children enrolled with the Comprehensive Medical and Dental Program (CMDP).

Please see the enclosed document for the proposed technical amendments. AHCCCS appreciates your consideration of this request, and looks forward to working with the Centers for Medicare & Medicaid Services to accomplish these changes.

Sincerely,



Thomas J. Betlach
Director

cc: Emmett Ruff, CMS
Megan Lepore, CMS
Bryan Zolynas, CMS

AHCCCS Complete Care Technical Clarification

CHANGES TO WAIVER AUTHORITIES

1. Proper and Efficient Administration Section

1902(a)(4) (42 CFR 438.52, 438.56)

To the extent necessary to permit the state to limit choice of managed care plans for Arizona Long Term Care System (ALTCS) Department of Economic Security/Division of Developmental Disabilities (DES/DDD) enrollees determined to have a qualifying Children's Rehabilitative Services (CRS) condition ~~choice of managed care plans~~ to a single Managed Care Organization (MCO) ~~the~~ Children's Rehabilitative Services Program (CRS) Contractor – for the treatment of CRS and behavioral health conditions, and to a single MCO for the treatment of physical health care conditions. ~~permit the state to limit choice of managed care plans for acute care enrollees with a CRS condition to a single MCO—the CRS program—for acute care as well as the treatment of CRS and behavioral health conditions.~~

To the extent necessary to permit the state to limit choice of managed care plans to a single MCO for individuals enrolled in the ALTCS and Comprehensive Medical and Dental Program (CMDP) programs so long as enrollees in such plans have a choice of at least two primary care providers, and may request change of primary care provider at least at the times described in 42 CFR 438.56(c). Notwithstanding this authority, the state must offer a choice of at least two MCOs to elderly and physically disabled individuals in Maricopa County.

To the extent necessary to permit the State to limit ~~acute care enrollees'~~ choice of managed care plans to a single Regional Behavioral Health Authority (RBHA) contracted with AHCCCS for the treatment of physical and behavioral (as well as CRS where applicable) health conditions for AHCCCS Acute Care Program (ACP) enrollees who have been determined to have a Serious Mental Illness (SMI).

~~To the extent necessary to permit the State to restrict beneficiaries' ability to disenroll without cause after an initial 30 day period from a managed care plan. Beginning October 1, 2017 the state must allow disenrollment without cause up to 90 days after enrollment into a managed care plan.~~

To the extent necessary to permit the state to restrict beneficiary disenrollment based on 42 CFR 438.56(d)(2)(v), which provides for disenrollment for causes including but not limited to, poor quality of care, lack of access to services covered under the contract, or lack of access to providers experienced in dealing with the enrollee's health care needs.

CHANGES TO SPECIAL TERMS AND CONDITIONS (STCs)

II. PROGRAM OVERVIEW AND HISTORICAL CONTEXT

Until 1982, Arizona was the only state that did not have a Medicaid program under title XIX of the Social Security Act. In October 1982, Arizona implemented the AHCCCS in the state's first section 1115 demonstration project. AHCCCS initially covered only acute care services, however, by 1989, the program was expanded to include the Arizona Long Term Care System (ALTCS), the state's capitated long term care ~~(LTC)~~ program for the elderly and physically disabled (EPD) and the developmentally disabled (DD) populations. In 2000, the state also expanded coverage to adults without dependent

children with family income up to and including 100 percent of the federal poverty level (FPL) as well as established the Medical Expense Deduction (MED) program for adults with income in excess of 100 percent of the FPL who have qualifying healthcare costs that reduce their income at or below 40 percent of the FPL. On March 31, 2011, Arizona requested to eliminate the MED program and implement an enrollment freeze on the adults without dependent children population. On April 30, 2011, and July 1, 2011, CMS approved the state's required phaseout plans for the MED program and the adults without dependent children population, respectively.

The demonstration provides health care services through a prepaid, capitated managed care delivery model that operates statewide for both Medicaid state plan groups as well as demonstration expansion groups. The goal of the demonstration is to test health care delivery systems to provide organized and coordinated health care for both acute and long term ~~services and supports care~~ that include pre-established provider networks and payment arrangements, administrative and clinical systems for utilization review, quality improvement, patient and provider services, and management of health services. The demonstration will also test the extent to which health outcomes in the overall population are improved by expanding coverage to additional needy groups.

The demonstration affects coverage for certain specified mandatory state plan eligibles by requiring enrollment in coordinated, cost effective, health care delivery systems. In this way, the demonstration will test the use of managed care entities to provide cost effective care coordination, including the effect of integrating behavioral and physical health services for ~~most AHCCCS members. individuals with serious mental illness and children participating in the Children's Rehabilitative Services program.~~ In addition, the demonstration will provide for payments to IHS and tribal 638 facilities to address the fiscal burden for certain services not covered under the state plan and provided in or by such facilities. This authority will enable the state to evaluate how this approach impacts the financial viability of IHS and 638 facilities and ensures the continued availability of a robust health care delivery network for current and future Medicaid beneficiaries. As part of the extension of the demonstration in 2016, based on CMS clarifying its policy for claiming 100 percent federal matching for services received through IHS and 638 facilities, the state can transition from the current uncompensated care reimbursement methodology to service-based claiming.

As part of the extension of the demonstration on October 1, 2016, beginning January 1, 2017 the state will implement its AHCCCS Choice Accountability Responsibility Engagement (CARE) program. Beneficiaries in the new adult group with incomes above 100 percent of the FPL are required to participate in AHCCCS CARE and will be required to make monthly contributions into AHCCCS CARE accounts. AHCCCS CARE will also provide certain incentives for timely payment of these monthly contributions and completion of "healthy targets" under the state's Healthy Arizona program that will also be implemented with AHCCCS CARE.

On January 18, 2017, an amendment was approved which established the "Targeted Investments Program." The state will direct its managed care plans to make specific payments to certain providers pursuant to 42 CFR 438.6(c), with such payments incorporated into the actuarially sound capitation rates, to incentivize providers to improve performance.

Specifically, providers will be paid incentive payments for increasing physical and behavioral health care integration and coordination for individuals with behavioral health needs.

The Targeted Investments Program will:

- Reduce fragmentation that occurs between acute care and behavioral health care,
- Increase efficiencies in service delivery for members with behavioral health needs, and
- Improve health outcomes for the affected populations.

V. DEMONSTRATION PROGRAMS

18. Arizona Acute Care Program (AACP). ~~Most AACP enrollees receive most integrated physical and behavioral health care Medicaid-covered services through a single the Managed Care Organization (MCO) Health Plans called an AHCCCS Complete Care (ACC) Plan. ,but receive, on a “carve-out” basis, behavioral health services through a separate MCO contract. The one exception to the behavioral health carve-out is for AACP members determined to have -with- a Serious Mental Illness (SMI) who receive integrated physical and behavioral their acute care and behavioral health services through a geographically designated Regional Behavioral Health Authority (RBHA). and AHCCCS contracted MCO. In addition, AACP members with a CRS condition receive all of their care—acute care and treatment for CRS and behavioral health care conditions— through a separate MCO contract.~~

- a) **Enrollment.** The Arizona DES processes applications and determines acute care Medicaid eligibility for children, pregnant women, families and non-disabled adults under the age of 65 years. The Social Security Administration (SSA) determines eligibility for the Supplemental Security Income (SSI) cash-related groups, and AHCCCS determines eligibility for the SSI- related aged and disabled groups, Medicare Savings Programs, women diagnosed with breast or cervical cancer, and Freedom to Work recipients. Individuals determined eligible must then select and enroll in a Health Plan, or they will be auto-assigned by the AHCCCS administration.
- b) **Benefits.** With the exception of the new adult group, benefits for AACP and the expansion population authorized by the 1115 demonstration will consist of all acute care benefits covered under the Medicaid state plan, unless otherwise noted within these STCs. The new adult group will receive benefits for AACP through the state’s approved alternative benefit plan (ABP) state plan amendment (SPA).
 - i. **Notice.** The state must include the CMS Central Office when submitting a SPA to the CMS Regional Office that would impact the expansion population authorized by the 1115 demonstration inclusive of:
 - a. The proposed date of implementation;
 - b. The date the state plans to submit the SPA; and
 - c. Revised budget neutrality projections.
 - ii. **Demonstration Amendment.** CMS reserves the right to require the state to submit an amendment if it is determined that it is warranted.
 - iii. Behavioral health services are outlined in Table 2 and subject to limitations set forth in the existing state plan.

Table 2 – AACP Behavioral Management

Benefit	Title XIX	Title XXI
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Age	< 21 yrs	> 21 yrs	< 19 yrs
Behavioral Management	X	X	X
Case Management	X	X	X
Emergency Behavioral Health Care	X	X	X
Evaluation	X	X	X
Therapeutic Residential Support (in home, excluding room and board)	X	X	X
Inpatient Services			
Inpatient Hospital	X	X	X
Inpatient Psychiatric Facilities	X	X	X
Lab & X – Ray	X	X	X
Medications (Psychotropic)	X	X	X
Medication Adjustment & Monitoring	X	X	X
Metadone / IAAM	X	X	X
Partial Care	X	X	X
Professional Services			
Individual	X	X	X
Group & Family	X	X	X
Psychosocial Rehabilitation	X	X	X
Respite (with limits)	X	X	X
Screening	X	X	X
Transportation – Emergency	X	X	X
Transportation – Non Emergency	X	X	X

c) **AACP Cost Sharing** – Cost sharing shall be imposed as specified in the Medicaid state plan for all populations.

26. Children in Foster Care. Services for Arizona’s children in foster care are provided through an MCO contract between AHCCCS and the Arizona Department of Child Safety (DCS) called the /Comprehensive Medical and Dental Program (CMDP). CMDP operates in the same manner as other AACP Health Plans, but eChildren in foster care who receive acute care services will be enrolled in CMDP instead of other Health Plans. Children in foster care who are eligible for or receive ALTCS will be enrolled or remain with the Program Contractor. Case Management services provided and reimbursed through this contractual relationship must be provided consistent with federal policy, regulations and law. Children in foster care receive behavioral health services through RBHAs. who are also eligible for CRS receive treatment for their CRS and behavioral health care conditions through the separate MCO contract for the CRS program. CRS eligible foster children will receive services for all conditions other than behavioral health or CRS related conditions through CMDP.

- a) **FFP.** FFP will not be available for:
- i. Duplicate payments made to public agencies or private entities under other program authorities for case management services or other Medicaid services for the same purpose; or
 - ii. Activities integral to the administration of the foster care program excluding any health care related activities.

27. Children Rehabilitative Services (CRS). ~~AHCCCS contracts on a sole source, capitated basis for the CRS program. Acute Care enrolled e~~Children with qualifying conditions receive ~~their~~CRS specialty care. Most individuals receive care for their CRS conditions as well as behavioral health care and

~~physical health acute care through an ACC plan, the CRS contractor.~~ Children enrolled in ALTCS/DES/DDD who also have a CRS condition ~~will~~ receive care for their CRS and behavioral health conditions through the CRS Contractor and treatment for ~~and physical behavioral~~ health conditions through a ALTCS/DES/DDD subcontractor, a ~~the CRS contractor.~~ Children with a CRS condition who are enrolled in CMDP ~~will~~ receive treatment for their CRS and physical health care conditions through CMDP and treatment for behavioral health care conditions through a RBHA. ~~the CRS contractor.~~

- a) **Transition of Care.** When individuals transition to the CRS contractor from an AACP health plan, children in active treatment (including but not limited to chemotherapy, pregnancy, drug regime or a scheduled procedure) with a CRS non-participating provider shall be allowed to continue receiving treatment from the non-participating provider through the duration of their prescribed treatment.
- b) **Choice of Primary Care Physician (PCP).** The CRS contractor is required to assure that members have a choice of PCPs. Specifically, beneficiaries will have a choice of at least two primary care providers, and may request change of primary care provider at least at the times described in 42 CFR 438.56(c). In addition, the CRS contractor will offer contracts to primary and specialist physicians who have established relationships with beneficiaries including specialists who may also serve as PCPs to encourage continuity of provider. For children who have an established relationship with a PCP that does not participate in the CRS contractor's provider network, the CRS contractor will provide, at a minimum, a 90-day transition period in which the child may continue to seek care from their established PCP while the child and child's parents and/or guardian, the CRS contractor, and/or case manager finds an alternative PCP within the CRS contractor's provider network.
- c) **Readiness Review of Health Plan.** The state will submit to CMS for review a copy of its readiness review report of the health plan selected to provide the integrated services to the CRS population to ensure the selected health plan's provider network, both in terms of primary and specialty care providers, is adequate and would not result in access to care issues for the affected population.

28. Individuals with Serious Mental Illness (SMI). Individuals who are AACP members and who are diagnosed with a serious mental illness will receive integrated physical their acute care services and behavioral health care services through a separate MCO called a RBHA. ~~RBHAs serve as subcontractors of AHCCCS.~~

- a) **Transition Period.** When individuals transition to the RBHA for their physical health from a ~~n-AACP hH~~ health ~~pP~~lan, members in active treatment (including but not limited to chemotherapy, pregnancy, drug regime or a scheduled procedure) with a non-participating/non-contracted provider shall be allowed to continue receiving treatment from the non-participating/noncontracted provider through the duration of their prescribed treatment.
- b) **Choice of Primary Care Physician (PCP).** The RBHA is required to assure that members have a choice of PCPs. Specifically, beneficiaries will have a choice of at least two primary care providers, and may request change of primary care provider at least at the times described

in 42 CFR 438.56(c). In addition, the RBHA, will offer contracts to primary and specialist physicians who have established relationships with beneficiaries including specialists who may also serve as PCPs to encourage continuity of provider. For individuals who have an established relationship with a PCP that does not participate in the /RBHA's provider network, the RBHA will provide, at a minimum, a 6-month transition period in which the individual may continue to seek care from their established PCP while the individual, the RBHA and/or case manager finds an alternative PCP within the /RBHA's provider network.

- c) **Opt out for Cause.** Individuals with SMI will have the option to opt-out of the RBHA for acute care services and be transferred to a Health Plan ~~the acute care plan~~ under the following conditions only:
- i. Either the beneficiary, beneficiary's guardian, or beneficiary's physician successfully dispute the beneficiary's diagnosis as SMI;
 - ii. Network limitations and restrictions, e.g. if a beneficiary's preferred provider is not contracted with a RHBA or there is only one provider in a service area and the provider is not contracted with a RBHA;
 - iii. Physician or provider course of care recommendation and subsequent review by the RBHA and the state;
 - iv. The member established that due to the enrollment and affiliation with the RBHA as a person with a SMI, and in contrast to persons enrolled with an acute care provider, there is demonstrable evidence to establish actual harm or the potential for discriminatory or disparate treatment in:
 - a. The access to, continuity or availability of acute care covered services;
 - b. Exercising client choice;
 - c. Privacy rights;
 - d. Quality of services provided; or
 - e. Client rights under Arizona Administrative Code, Title 9, Chapter 21.
- d) Under paragraph 28 subparagraph (c)(iv), a beneficiary must either demonstrate that the discriminatory or disparate treatment has already occurred, or establish the plausible potential of such treatment. It is insufficient for a member to establish actual harm or the potential for discriminatory or disparate treatment solely on the basis that they are enrolled in the RBHA.
- e) A transfer requested under paragraph 28 subparagraph (c)(iv) will be clearly documented in the enrollee handbook and any other relevant enrollee notices, and will be processed as follows:
- i) The RBHA will take the following actions:
 - a. Responsibility for reducing to writing the member's assertions of the actual or perceived disparate treatment of individuals as a result of their enrollment in the integrated plan.
 - b. Responsibility for completing AHCCCS transfer of a RBHA member to an approved Acute Care Contractor Form.

- c. Confirmation and documentation that the member is enrolled in SMI RBHA program.
- d. Providing documentation of efforts to investigate and resolve member's concern.
- e. Inclusion of any evidence provided by the member of actual or reasonable likelihood of discriminatory or disparate treatment.
- f. Making a recommendation to approve or decision to deny the request:
 - 1) For making recommendations to approve, forward completed packet to AHCCCS for a determination decision within 7 days of request.
 - 2) For decision to deny, complete packet and provide member with a written denial notice within 10 calendar days of request that includes the reasons for the denial and appeal/hearing rights.

ii) AHCCCS will take the following actions:

- a. For recommendations made by the RBHA to approve, review the completed request packets and make a final decision to approve or deny the request.
 - b. For denials, provide member written notice of the denial within 10 calendar days of the request that includes the reasons for the denial and appeal/hearing rights.
 - c. If a hearing is requested, the request for hearing will be forwarded to the AHCCCS Administration which will then schedule the matter for hearing with OAH;
 - d. The AHCCCS Administration will issue a Director's Decision within 30 calendar days of receipt of the ALJ Decision.
- f) The state will track the Opt-out for Cause requests detailed in paragraph 28, subparagraph (c) including the number of each type of request; the county of each request; and the final result of the request. This information shall be provided to CMS in the quarterly reports.
- g) **Care Coordination for Integrated SMI Program.** The State shall submit to CMS their procedures for ensuring that the integrated RBHAs have sufficient resources and training available to provide the full range of care coordination for individuals with disabilities, multiple and chronic conditions, and individuals who are aging. Care coordination capacity should reflect demonstrated knowledge and capacity to address the unique needs (medical, support and communication) of individuals in the SMI population. The needs may be identified through a risk assessment process. Care shall be coordinated across all settings including services outside the provider network.

VII. DELIVERY SYSTEMS

34. Arizona Acute Care Program (AAP). The AAP is a statewide, managed care system, which delivers acute care services through ~~contracts with prepaid, capitated~~ Managed Care Organizations (MCOs) that AHCCCS calls "Health Plans." Most AAP enrollees receive integrated physical and behavioral health care services through a single ACC Plan, and most individuals with CRS conditions also receive treatment for those conditions through an ACC Plan. AAP members determined to have a SMI receive integrated physical and behavioral health services through a geographically designated RBHA. Physical health care services for Arizona's children in foster care are provided through the CMDP while behavioral health services are provided through RBHAs. Most Health Plan contracts are awarded by Geographic Service Area (GSA), which is a specific county or defined grouping of counties designated by AHCCCS within which a Health Plan Contractor provides, ~~directly or through subcontract,~~ covered health care services to members enrolled with that Health Plan Contractor.

35. Arizona Long Term Care System Services (ALTCS). ~~The~~ ALTCS is administered through a statewide, managed care system which delivers physical acute, behavioral, long-term services and supports care (including, home-and-community based services), and treatment for CRS conditions and behavioral health care services through ~~contracts with capitated~~ MCOs that AHCCCS calls "Program Contractors." ALTCS members in the Elderly and Physically Disabled (EPD) population, including those determined to have a SMI, receive integrated care through ALTCS/EPD Program Contractors. ALTCS members with a developmental disability (DD) receive physical health care through an MCO subcontracted with the Arizona Department of Economic Security/Division of Developmental Disabilities (DES/DDD), behavioral health care through a RBHA, and long-term services and supports care through DES/DDD. The one exception is ALTCS-DES/DDD enrollees eligible under the CRS program receive specialty care for treatment of their CRS and behavioral health conditions through a separate MCO contract. Those enrollees will receive services for all conditions other than behavioral health or CRS-related conditions through ALTCS-DES/DDD.

~~With one exception,~~ ALTCS/EPD contracts are awarded in the same geographic service areas as the ACC Plans. AAP are awarded. ALTCS/EPD enrollees in Maricopa and Pima Counties have a choice of Program Contractors, but ALTCS/EPD enrollees in the rest of the state enroll in the Program Contractor for their GSA.

~~The exception is for t~~he ALTCS contract with the Arizona DES/DDD ~~to~~ provides coverage on a statewide basis of the full ALTCS benefit package to all eligible individuals with developmental disabilities. Under state law, A.R.S. 36-2940, AHCCCS is required to enter into an intergovernmental agreement (IGA) with DES/DDD to serve as the Program Contractor managed care organization for individuals with developmental disabilities. The DES/DDD ALTCS contract is an at-risk MCO contract that complies with 42 C.F.R. Part 438 and as such is reviewed and approved by CMS. Payments to DES/DDD under the ALTCS contract shall not include any payments other than payments that meet the requirements of 42 C.F.R. 438.6(c) including the requirement that all payments and risk-sharing mechanisms in the contract are actuarially sound. State law, A.R.S. 36-2953, requires DES/DDD to maintain a separate fund to account for all revenues and expenditures under the ALTCS contract and limits use of the fund for the administration of the ALTCS contract. ALTCS/EPD enrollees in Maricopa and Pima Counties have a choice of Program Contractors, but ALTCS/EPD enrollees in the rest of the state enroll in the Program Contractor for their GSA.

36. Children Rehabilitative Services (CRS). ~~AHCCCS contracts on a sole source, capitated basis for the CRS program.~~ Most AHCCCS members with a qualifying CRS condition receive integrated care for physical, behavioral, and CRS conditions through an ACC plan. Children in foster care with a qualifying CRS condition receive treatment for CRS and physical health care conditions through the CMDP and treatment for behavioral conditions through a RBHA. ALTCS/DD members with a qualifying CRS condition receive treatment for CRS and behavioral health conditions through the CRS Contractor, treatment for physical conditions through a MCO subcontracted with the DES/DDD, and long-term services and support through DES/DDD.

37. Regional Behavioral Health Authorities (RBHAs). Individuals who are AACP members and who are diagnosed with a serious mental illness will receive their acute care services and behavioral health services through ~~a~~ separate MCOs called ~~a~~ RBHAs. RBHAs also serve children in foster care and ALTCS/DES/DDD members.

VIII. DEMONSTRATION MONITORING AND REPORTING

43. Contractor Reviews. The state will forward summaries of the financial and operational reviews that: ~~a)~~ The Arizona Department of Economic Security/Division of Developmental Disabilities (DES/DDD) performs on its subcontracting MCOs. ~~b)~~ The state will also forward summaries of the financial and operational reviews that AHCCCS completes on ~~the Children's Rehabilitative Services Program (CRS) contractor; and~~ the Comprehensive Medical and Dental Program (CMDP) at the Arizona DCS.

X. EVALUATION OF THE DEMONSTRATION

44. Draft Evaluation Design. Within 120 days of each approved demonstration period, the state must submit a draft evaluation design for CMS comment and approval. The design must meet all the requirements of 42 CFR 431.424. The state must also submit a revised evaluation design that adds additional measures associated with changes to the demonstration approved as part of an amendment. The evaluation design for the demonstration period beginning October 1, 2016 must include research questions, hypotheses and proposed measures for the AHCCCS CARE program post-implementation, Healthy Arizona program and a continuation of the state's evaluation of the integration of physical and behavioral health under the RBHAs. ~~and CRS plans.~~