Arizona's Medicaid Reform Plan
AHCCCS Activities

On March 15, 2011, Governor Brewer announced a plan to preserve Arizona's Medicaid program through reforms designed to reduce costs by an estimated $500 million in the State's General Fund. Many provisions of the plan are subject to federal approval. Below is information regarding implementation of the plan and the status of AHCCCS progress and federal approval. This document will be updated regularly.

A. Medicaid Eligibility Reforms

1. Changes to Childless Adults Program and Enrollment Freeze (Eff. 7/1/2011)

The Childless Adult program is for those persons not otherwise eligible for Medicaid[1] with income up to 100% FPL. As of May 1, 2011, there were 221,952 childless adults. Eligibility for Childless Adults is derived exclusively from the AHCCCS 1115 Waiver. In a letter dated February 15, 2011, the Centers for Medicare and Medicaid Services (CMS) confirmed that Arizona would not be in violation of the Maintenance of Effort (MOE) requirements in the Affordable Care Act (ACA) if it did not renew coverage for this waiver population.

Rather than eliminate coverage for the Childless Adults altogether, the revised Waiver Renewal seeks to change the nature of the Childless Adult program in Arizona from an open-ended entitlement program to one based on available funds. This would provide the State with the flexibility to manage enrollment based on available funding, including adding to enrollment if additional funds are made available. To meet current budget requirements, the proposal seeks to freeze enrollment July 1, 2011. Individuals enrolled prior to July 1 would retain their coverage, but no new individuals would be made eligible in this category unless additional funding becomes available. The proposal also includes an incentives strategy coupled with an annual fee to encourage healthy behaviors, as well as changing redeterminations from 12-months to 6-months. No children, elderly or individuals meeting the federal definition of disability will be impacted by this enrollment freeze or the incentives/fee strategy.

→ *AHCCCS Progress*:

- March 31, 2011: AHCCCS submitted its revised Waiver Renewal to CMS.
- April 11, 2011: AHCCCS submitted a transition plan for the freeze and phase out of the existing Childless Adult program for CMS approval.
- May 2, 2011: Notice of Proposed Exempt Rule Making was posted on the AHCCCS website.
- June 20, 2011: The 30-day comment period closes.

2. Medical Expense Deduction program Phase-Out (Begin Phase Out 5/1/2011)

The Medical Expense Deduction (MED) program is for those individuals not otherwise eligible for AHCCCS under any other category and who have medical expenses that reduce their income below 40% FPL. As of May 1, 2011, there were 6,035 MED members. Eligibility for MED is derived exclusively from the AHCCCS 1115 Waiver. In a letter dated February 15, 2011, CMS confirmed that Arizona would not be in violation of the MOE requirements in the ACA if it did not renew coverage for this waiver population.

On March 31, 2011, AHCCCS submitted its revised Waiver Renewal to CMS, which does not renew coverage for the MED program after the expiration of the current waiver on September 30, 2011. Beginning May 1, enrollment for the MED program is frozen and no new applications will be accepted for this category pursuant to the MED Phase-Out Plan approved by CMS. All individuals currently enrolled in the MED program will retain their coverage. Since eligibility for MED does not exceed 6 months, the May 1 freeze has the effect of eliminating the MED program by October 1, 2011.

[1] That is, they are not age 65 or older, blind, disabled, pregnant or do not have deprived dependent children in their household.

→ *AHCCCS Progress*:

- March 16, 2011: A draft MED Phase Out Plan was submitted to CMS for approval.
- March 17, 2011: Notification of the Phase Out plan and the Notice of Proposed Exempt Rule Making were posted on the AHCCCS website.
- April 18, 2011: The 30-day comment period closed; comments are posted on the website.
- April 29, 2011: CMS approves the MED Phase-Out Plan.

3. Freeze New Enrollment of Parents between 75-100% FPL (Eff. 10/1/11)

Coverage of parents between 75-100% FPL is an optional Medicaid expansion group under Section 1931 and Arizona's State Plan. This group is also referred to as TANF parents. About 60,000 parents between 75-100% FPL are enrolled in AHCCCS.

The proposal would freeze enrollment for new parents between 75-100% FPL and no new applicants would be accepted in this category. Individuals already enrolled would retain their coverage. No children would be impacted by this enrollment freeze. In order to freeze eligibility for this income level, CMS must approve a waiver of the MOE requirement in the ACA.

→ *AHCCCS Progress*: March 31: AHCCCS revised Waiver Renewal to CMS includes this request.

4. Eliminate Federal Emergency Services (FES) (Eff.: 10/1/11)

Persons who qualify for Federal Emergency Services (FES) meet all other eligibility requirements for Medicaid under Arizona's State Plan except for citizenship or qualified alien status. Services are limited to those required to treat an emergency medical condition as defined by federal law. The proposal eliminates FES coverage. Eliminating this eligibility category would require a waiver of the MOE requirement in the ACA.

→ *AHCCCS Progress*: March 31: AHCCCS revised Waiver Renewal to CMS includes this request.

5. Six Month Eligibility Redeterminations (Eff. 10/1/11)

States have discretion to establish the frequency of eligibility redeterminations as long as redetermination occurs at least every 12 months. The proposal is seeking to change the redetermination time frame from every 12 months to every 6 months for 1931 parents and childless adults to ensure that only those persons who meet the eligibility requirements are maintained on the program. In order to implement this change for non-waiver groups (i.e. parents), CMS must approve a waiver of the MOE requirement in the ACA.

→ *AHCCCS Progress*: March 31: AHCCCS revised Waiver Renewal to CMS includes this request.

B. Personal Responsibility Reforms

6. Expand Mandatory Copayments and Cost Sharing (Eff. 10/1/11)

A *mandatory* copayment is an amount paid by the AHCCCS member directly to a provider in order to receive a Medicaid covered service; services can be denied for failure to pay a mandatory copayment. Federal law only permits mandatory copayments for limited populations. AHCCCS currently has reached maximum limits on mandatory copayments for AHCCCS members as permitted by federal law. Thus, to expand mandatory copayments, AHCCCS requires waiver authority from CMS.

The proposal expands mandatory copayments for all adults and children to the same levels as the Transitional Medical Assistance population and adds copayments for non-emergency use of the emergency room as a requirement before receiving services. The proposal also requires annual fees for childless adult members who smoke, or who fail to meet steps that are within their control and outlined by their physician to manage a chronic disease.

→ *AHCCCS Progress*: March 31: AHCCCS revised Waiver Renewal to CMS includes this request.

7. Penalty for Missed Appointments (Eff. 10/1/11)

In an effort to increase member accountability and provider satisfaction during a period of decreased funding for the program, the proposal includes a measure to allow healthcare providers to impose a charge for missed appointments. Missed appointment penalties are permitted in Medicare and similar charges are required of commercially insured patients. In February 2009, AHCCCS requested CMS guidance regarding charges by healthcare providers for missed appointments. CMS indicated longstanding policy prohibits charging Medicaid recipients a missed appointment penalty.

→ *AHCCCS Progress*: March 31: AHCCCS revised Waiver Renewal to CMS includes this request.

C. Benefit Reforms

8. Restore Transplants Previously Covered (Eff. 4/1/11)

Federal law requires mandatory services be provided to all Medicaid members and allows states to cover additional optional services. Federal law also permits states to place limits on services as long as the services are sufficient in amount, duration, and scope to reasonably achieve their purpose. Coverage of transplants is optional and AHCCCS' federal authority to cover transplants derives from the State Plan. On October 1, 2010, AHCCCS implemented a number of benefit limits including the elimination of certain transplant types for persons age 21 years and older. The Governor's plan included restoring coverage for these transplants.

→ *AHCCCS Progress*:

- April 1, 2011: AHCCCS restores transplants previously covered.
- April 7, 2011: Notice of Proposed Exempt Rule Making was published on the website.
- April 21 2011: AHCCCS submits SPA #11-005 to CMS
- May 6, 2011: the public comment period closed.

9. Impose Benefit/Service Limits (Eff. 10/1/11)

Federal law requires mandatory services be provided to all Medicaid members and allows states to cover additional optional services. Federal law also permits states to place limits on services as long as the services are sufficient in amount, duration, and scope to reasonably achieve their purpose.

State Plan Changes. The proposal includes the following changes to the State Plan:

- 25-day inpatient hospital limit for adults; and
- 12-visit limit to the emergency department for adults.

→ *AHCCCS Progress*: June 2011: Additional information will be available on the website including a fact sheet, FAQs, a Notice of Proposed Exempt Rule Making and a State Plan Amendment.

Policy Changes. The proposal includes the following changes to AHCCCS policy:

- Reduction in the amount of respite hours covered for Long Term Care members and enrollees receiving Behavioral Health Services (amount to be determined). Respite is a waiver service and limitations are listed in rule and in the AHCCCS Medical Policy Manual (AMPM).

→ *AHCCCS Progress*:

- June 23, 2011: AHCCCS will hold a public meeting to discuss the agency's specific proposal regarding reduction of respite hours. Following the public meeting, AHCCCS changes will include a Notice of Proposed Exempt Rule Making and a change in the AMPM.

10. Eliminate Non-Emergency Medical Transportation (Eff. 10/1/11)

Federal law requires non-emergency medical transportation (NEMT) be provided to all Medicaid recipients. The proposal eliminates NEMT for non-disabled childless adults and non-disabled parents in the expansion population in Maricopa and Pima counties, and institutes copayments for NEMT for non-disabled childless adults and non-disabled parents in all other counties. In order to implement this proposal, AHCCCS must obtain a waiver from federal regulations.

→ *AHCCCS Progress*:

- August 2010: AHCCCS requested authority to waive the requirement to provide NEMT for childless adults and individuals in the MED program in Maricopa and Pima counties.
- December 2010: CMS denies request.
- March 31, 2011: AHCCCS submits revised Waiver Renewal to CMS including this request and proposing to review utilization data after one year and, if it is determined that the change resulted in a significant restriction in access to care, restore the benefit.

D. Other Reforms

11. Modify Reimbursement Rates (Eff. 10/1/11)

The proposal reduces provider rates and managed care organization payments and eliminates the growth in outlier payments. Currently, AHCCCS anticipates that all provider rates will be reduced by 5% with exemptions *only* for Indian Health Services and 638 facilities receiving 100% federal pass-through funding, and hospice rates, which are set by the federal government. These changes will be made through the State Plan Amendment process.

→ *AHCCCS Progress*: June 2011: Additional information will be on the website. This will include a Notice of Proposed Exempt Rule Making and a State Plan Amendment.

12. State Reimbursement of Medicare Liability (Eff. 10/1/11)

For over three decades, state Medicaid programs, including Arizona, have paid for health care coverage for individuals who were eligible for Medicare but were not enrolled in Medicare because of errors in the methodology used by the Social Security Administration (SSA) to determine federal disability benefits. The SSA has acknowledged this error and implemented the Special Disability Workload (SDW) project to correct the error. The proposal seeks $40 million in reimbursements for payments that were made by the State but should have been made by Medicare. More information on this issue can be found here: Background on Medicare Liability.

→ *AHCCCS Progress:* March 31: AHCCCS revised Waiver Renewal to CMS includes this request.

13. Avoid Indian Health Service Cost Shift (Eff. 10/1/11)

AHCCCS provides care for qualified American Indians who receive services at the Indian Health Services (IHS) or 638 facilities with 100% federal dollars. This proposal seeks federal authority to exempt benefit restrictions and eligibility changes for those services and benefits obtained through IHS or 638 facilities to ensure the viability of their programs. In addition, the State is still seeking similar authority to exempt benefits eliminated on October 1, 2010. More information about this request can be found on the Federal Activities page.

→ *AHCCCS Progress*: March 31: AHCCCS revised Waiver Renewal to CMS includes this request.

Future Long Term Reforms:

14. Innovations in Medicaid

While Arizona is nationally recognized as one of the most integrated and efficient Medicaid models in the country, opportunities exist to continue to innovate and build upon AHCCCS' mature model. Specifically, AHCCCS is seeking authority in the following areas:

- ***Payment Reform***. AHCCCS is seeking the ability to partner with providers and health plans to improve quality outcomes. To support those types of initiatives, AHCCCS needs waiver authority to allow the agency to enter into shared saving arrangements to reward health plans and providers for achieving goals, such as reducing hospital admissions or readmissions.
- ***Care Integration***. In her letter to Arizona from February 15, 2011, Secretary Sebelius identified care integration as a means of improving quality and achieving cost efficiencies in the Medicaid program. Specifically, the Secretary highlighted the need for Arizona to consider revising its current policy of maintaining a carved out behavioral health benefit. Accordingly, the State is considering ways to integrate care in two areas:
  - Integrating care for Children's Rehabilitative Services. AHCCCS will be exploring opportunities to further integrate care for special needs children, such as creation of a specialty health plan. This process will include an extensive consumer engagement strategy. AHCCCS is partnering with St. Luke's Health Initiatives to assist in this effort. This strategy will also include opportunities for input and collaboration with the provider community and other stakeholders.
  - Integrating care for the Seriously Mentally Ill (SMI) and Dual eligibles. AHCCCS will be working with the Arizona Department of Health Services to explore the development of health homes for SMIs and the creation of a specialty plan for the SMI population. This process will also include an extensive consumer engagement strategy. AHCCCS is partnering with St. Luke's Health Initiatives to assist in this effort. There will also be opportunities for input and collaboration with the provider community and other stakeholders.

→ *AHCCCS Progress:*

- March 11, 2011: AHCCCS submits its planning grant proposal under the ACA §2703- "Health Homes for Enrollees with Chronic Conditions" to develop integrated health homes for SMIs.
- March 29, 2011: CMS awards AHCCCS planning grant funding.
- March 31, 2011: AHCCCS submits revised Waiver Renewal to CMS including this request.