April 12, 2022

Sarah deLone, Director
Children and Adults Health Programs Group
Center for Medicaid and CHIP Services
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Dear Ms. deLone:

Upon the end of the Public Health Emergency, Arizona will have a large volume of eligibility and enrollment actions to complete. Arizona anticipates severe operational and systems challenges in the timely completion of these eligibility and enrollment actions in large part due to an unprecedented caseload of renewals that the state will need to process, coupled with significant staffing shortages that the state currently faces.

The March 3, 2022 Centers for Medicare & Medicaid Services (CMS) State Health Official (SHO) letter #22-001, "*Promoting Continuity of Coverage and Distributing Eligibility and Enrollment Workload in Medicaid, the Children's Health Insurance Program (CHIP), and Basic Health Program (BHP) Upon Conclusion of the COVID-19 Public Health Emergency*," describes strategies states may request to assist in addressing the challenges states may face as part of a transition to routine operations. CMS can authorize these strategies under Section 1902(e)(14)(A) of the Social Security Act ("1902(e)(14)(A) strategies").

During this transition period, Arizona is requesting that CMS approve the 1902(e)(14)(A) strategies outlined below to protect beneficiaries from inappropriate terminations and reduce state administrative burden:

1. Ex Parte Renewal for Individuals with No Income and No Data Returned

Arizona requests to temporarily complete the income determination for *ex parte* renewals without requesting additional income information or documentation if: (1) an attestation of zero-dollar income was verified within the last twelve months, at the initial application or the previous renewal; and (2) the state has checked financial data sources in accordance with its verification plan and no information is received. This authority is needed to address the extraordinarily high volume of renewals and other eligibility and enrollment actions that we will need to conduct during the unwinding period This flexibility will help alleviate significant additional strain on the State's workforce through the unwinding period, which is already

experiencing shortages. It will also reduce burden for customers, enhancing efforts to retain coverage for customers who remain eligible.

Arizona will continue to take appropriate steps to complete an *ex parte* determination of the non-financial components of eligibility consistent with the state's existing policies and procedures, outlined in the state's verification plan implementing 42 C.F.R. §§ 435.916 and 435.956. Arizona requests that this authority apply to Medicaid and CHIP populations.

Arizona requests that this authority be effective June 1, 2022 and remain effective for renewals initiated through the end of our 12-month unwinding period, as defined in SHO #22-001].

2. Facilitating Renewal for Individuals with no Asset Verification System (AVS) Data Returned within a Reasonable Timeframe

Arizona requests that CMS grant time-limited authority to assume there has been no change in resources that are verified through the AVS when no information is returned through the AVS or when the AVS call is not returned within a reasonable timeframe, and to complete an *ex parte* renewal process without any further verification of assets. This authority is needed to address the extraordinarily high volume of renewals and other eligibility and enrollment actions that we will need to conduct during the unwinding period. This flexibility will help alleviate significant additional strain on the State's workforce through the unwinding period, which is already experiencing shortages. It will also reduce delays in processing renewals and redeterminations and help the state meet the required timeframes for unwinding provided in recently issued guidance..

If the state receives information from the AVS indicating potential ineligibility after a beneficiary has received notice that their coverage has been renewed, the state will treat such information as a change in circumstances that may affect eligibility and redetermine the beneficiary's eligibility in accordance with 42 C.F.R. § 435.916(d). The state also assures that it will notify individuals whose eligibility is renewed using this authority that they must inform the agency if any of the information relied upon by the state is inaccurate, consistent with 42 C.F.R. § 435.916(a)(2)(ii), and that it will redetermine the beneficiary's eligibility in accordance with 42 C.F.R. § 435.916(d) if the individual informs the agency of any such inaccuracies that may impact eligibility.

Arizona requests that this authority be effective June 1, 2022 and remain effective for renewals initiated through the end of our 12-month unwinding period, as defined in SHO #22-001.

3. *Partnering with Managed Care Plans to Update Beneficiary Contact Information*

Arizona requests to temporarily permit the acceptance of updated enrollee contact information from managed care plans without additional confirmation from the individual. Under this authority, the state would treat updated contact information confirmed by and received from the plan as reliable and update the beneficiary record with the new contact information without first sending a notice to the beneficiary address on file with the state. This request is based on identified system or operational issues that prevent Arizona from implementing the policy to first contact the beneficiary to confirm the accuracy of updated contact information received

from managed care plans prior to entering the updated contact information received into its system as the address of record. Our systems or operational issues are related to our eligibility systems, workforce shortages, and limited resources that do not support automating any part of the process. Without automation, the process would require an unsustainable level of effort on the part of the state's managed care organizations. Given that Arizona would not be able to partner with managed care plans to update beneficiary contact information without this authority, Arizona is seeking this authority to protect beneficiaries in the aggregate by reducing the risk of procedural terminations for many beneficiaries. Arizona requests that this authority apply to Medicaid and CHIP populations.

In implementing this option, Arizona assures that:

- The managed care plans only provide updated contact information received directly from or verified with the beneficiary, an adult who is in the beneficiary's household or family, or the beneficiary's authorized representative recognized by the health plan. The state will not accept contact information provided to the plan by a third party or other source if not independently verified by the plan with the beneficiary, an adult who is in the beneficiary's household or family, or the beneficiary's authorized representative recognized by the health plan; and

- The beneficiary contact information provided by the managed care plan is more recent than the information on file with the state

Arizona requests that this authority be effective upon approval and remain effective until 14 months after the end of the month in which the public health emergency for COVID-19, as declared by the Secretary of Health and Human Services under section 319 of the Public Health Service Act (42 U.S.C. § 247d), ends.

4. ***Extended Timeframe to Take Final Administrative Action on Fair Hearing Requests***

Arizona requests to temporarily extend the timeframe permitted for the state to take final administrative action on fair hearing requests, excluding requests for an expedited fair hearing in accordance with 42 C.F.R. § 431.224. As part of this request, Arizona assures that it will:

- Provide benefits pending the outcome of a fair hearing decision (including reinstating benefits), regardless of whether or not a beneficiary has requested a fair hearing prior to the date of the adverse action or whether the beneficiary has requested benefits pending;

- Not extend the timeframe to take final administrative action for a fair hearing request where benefits cannot be provided pending the outcome of the fair hearing, such as an appeal of denial of eligibility for a new applicant;

- Not recoup the cost of benefits pending from the beneficiary, regardless of whether the fair hearing ultimately upheld the agency's determination; and

- Not use this authority as a justification to delay taking final action, and only use this authority to the extent to which the state is unable to take final agency action on a given fair hearing.

Factors that support this request include: an insufficient number of hearing officers, anticipated increase in fair hearing volume, and other workforce shortages impacting staff that support the appeals process. Without this authority Arizona is at risk of being unable to take final administrative action on the extraordinarily high volume of fair hearings that we anticipate during the unwinding period within the maximum 90-day time limit allowed under 42 C.F.R. 431.244.

Arizona requests that this authority be effective June 1, 2022 and remain effective until the end of the 23rd month after the end of the month in which the public health emergency for COVID-19, as declared by the Secretary of Health and Human Services under section 319 of the Public Health Service Act (42 U.S.C. §247d), ends.

Arizona looks forward to your review and approval of this request. If you have any questions or concerns, please contact Ruben Soliz at rube.soliz@azahcccs.gov.

Sincerely,

Dana Flannery
Senior Policy Advisor and Assistant Director
Arizona Healthcare Cost Containment System, (AHCCCS)