State: ARIZONA

| Citation | Condition or Requirement |
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1932(a)(1)(A)

A. Section 1932(a)(1)(A) of the Social Security Act.

The State of Arizona enrolls Medicaid beneficiaries on a **voluntary** basis into managed care entities (managed care organization (MCOs) and/or primary care case managers (PCCMs)) in the absence of section 1115 or section 1915(b) waiver authority. This authority is granted under section 1932(a)(1)(A) of the Social Security Act (the Act). Under this authority, a state can amend its Medicaid state plan to require certain categories of Medicaid beneficiaries to enroll in managed care entities without being out of compliance with provisions of section 1902 of the Act on statewideness (42 CFR 431.50), freedom of choice (42 CFR 431.51) or comparability (42 CFR 440.230).

This authority may ***not*** be used to mandate enrollment in Prepaid Inpatient Health Plans (PIHPs), Prepaid Ambulatory Health Plans (PAHPs), nor can it be used to mandate the enrollment of Medicaid beneficiaries described in 42 CFR 438.50(d).

Where the state's assurance is requested in this document for compliance with a particular requirement of 42 CFR 438 et seq., the state shall place check mark to affirm such compliance.

1932(a)(1)(B)(i)
1932(a)(1)(B)(ii)
42 CFR 438.50(b)(1)-(2)

B. Managed Care Delivery System.

The State will contract with the entity(ies) below and reimburse them as noted under each entity type.

1. ☐ MCO
   a. ☐ Capitation

2. ☒ PCCM (individual practitioners)
   a. ☒ Case management fee
   b. ☐ Bonus/incentive payments
   c. ☐ Other (please explain below)

3. ☐ PCCM (entity based)
   a. ☐ Case management fee
   b. ☐ Bonus/incentive payments
   c. ☐ Other (please explain below)

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For states that elect to pay a PCCM a bonus/incentive payment as indicated in B.2.b. or B.3.b, place a check mark to affirm the state has met ***all*** of the following conditions (which are representative of the risk incentive rules for managed care contracts published in 42 CFR 438.6(c)(5)(iv)).

☐a. Incentive payments to the PCCM will not exceed 5% of the total FFS payments for those services provided or authorized by the PCCM for the period covered.

☐b. Incentives will be based upon a fixed period of time.

☐c. Incentives will not be renewed automatically.

☐d. Incentives will be made available to both public and private PCCMs.

☐e. Incentives will not be conditioned on intergovernmental transfer agreements.

☐f. Incentives will be based upon specific activities and targets.

CFR 438.50(b)(4) C. Public Process.

Describe the public process including tribal consultation, if applicable, utilized for both the design of the program and its initial implementation. In addition, describe what methods the state will use to ensure ongoing public involvement once the state plan program has been implemented. *(Example: public meeting, advisory groups.)*

*The concept of primary care coordination model and a per member per month (PMPM) payment strategy as an American Indian Medical Home (AIMH) was initially brought forth by the Tucson area IHS and was the subject of formal AHCCCS tribal consultation in March and August of 2011. The proposal for an American Indian Medical Home was also placed on the AHCCCS website for public comment during this period.*

*AHCCCS refined the care coordination model for an AIMH to align this effort with the IHS Improving Patient Care (IPC) model to avoid duplication and confusion among care coordination models. This revised proposal was the subject of Tribal Consultation in August, 2013 and at the request of Tribal stakeholders was revised to include diabetes education in 2014. Additional revisions from tribes were included in*

*the model presented at a Tribal Consultation in August, 2015. As negotiations over the model progressed and substantial changes were made AHCCCS presented the current model at Tribal Consultation in January, April, July and October, 2016.*

*Public notice and Tribal Consultation for this State Plan Amendment occurred on February 9, 2017. In addition, AHCCCS has a website on which program changes are posted and comments are received. The State will continue to follow its State plan public notice and Tribal Consultation processes for all program changes affecting the AIMH.*

D. State Assurances and Compliance with the Statute and Regulations.

If applicable to the state plan, place a check mark to affirm that compliance with the following statutes and regulations will be met.

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| Citation | | Condition or Requirement |
|---|---|---|
| 1932(a)(1)(A)(i)(I) | 1. | ☐The state assures that all of the applicable requirements of section 1903(m) of the Act, for MCOs and MCO contracts will be met |
| 1932(a)(1)(A)(i)(I)<br>1905(t)<br>42 CFR 438.50(c)(2)<br>1902(a)(23)(A) | 2. | ⬓The state assures that all the applicable requirements of section 1905(t) of the Act for PCCMs and PCCM contracts will be met. |
| 1932(a)(1)(A)<br>42 CFR 438.50(c)(3) | 3. | ☐The state assures that all the applicable requirements of section 1932 (including subpart (a)(1)(A)) of the Act, for the state's option to limit freedom of choice by requiring Beneficiaries to receive their benefits through managed care entities will be met. |
| 1932(a)(1)(A)<br>42 CFR 431.51<br>1905(a)(4)(C) | 4. | ☐ The state assures that all the applicable requirements of 42 CFR 431.51 regarding freedom of choice for family planning services and supplies as defined in section 1905(a)(4)(C) will be met. |
| 1932(a)(1)(A) | 5. | ⬓The state assures that it appropriately identifies individuals in the mandatory exempt groups identified in 1932(a)(1)(A)(i). |
| 1932(a)(1)(A)<br>42 CFR 438<br>1903(m) | 6. | ⬓The state assures that all applicable managed care requirements of 42 CFR Part 438 for MCOs and PCCMs will be met. |
| 1932(a)(1)(A)<br>42 CFR 438.6(c)<br>42 CFR 438.50(c)(6) | 7. | ☐The state assures that all applicable requirements of 42 CFR 438.6(c) for payments under any risk contracts will be met. |
| 1932(a)(1)(A)<br>CFR 447.362<br>42 CFR 438.50(c)(6) | 8. | ☐The state assures that all applicable requirements of 42 CFR 447.362 for 42 payments under any non-risk contracts will be met. |
| 45 CFR 92.36 | 9. | ⬓The state assures that all applicable requirements of 45 CFR 92.36 for procurement of contracts will be met. |

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Citation | Condition or Requirement

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1932(a)(1)(A)
1932(a)(2)

E. Populations and Geographic Area

1. **Included Populations.** Please check which eligibility populations are included, if they are enrolled on a mandatory (M) or voluntary (V) basis, and the geographic scope of enrollment. Under the geography column, please indicate whether the nature of the population's enrollment is on a statewide basis, or if on less than a statewide basis, please list the applicable counties/regions.

| Population | M | Geographic Area | V | Geographic Area | Excluded |
|---|---|---|---|---|---|
| Section 1931 Children & Related Populations – 1905(a)(i) | | | | | |
| Section 1931 Adults & Related Populations1905(a)(ii) | | | | | |
| Low-Income Adult Group | | | | | |
| Former Foster Care Children under age 21 | | | | | |
| Former Foster Care Children age 21-25 | | | | | |
| Section 1925 Transitional Medicaid age 21 and older | | | | | |
| SSI and SSI related Blind Adults, age 18 or older* - 1905(a)(iv) | | | | | |
| Poverty Level Pregnant Women – 1905(a)(viii) | | | | | |
| SSI and SSI related Blind Children, generally under age 18 – 1905(a)(iv) | | | | | |
| SSI and SSI related Disabled children under age 18 | | | | | |
| SSI and SSI related Disabled adults age 18 and older – 1905(a)(v) | | | | | |
| SSI and SSI Related Aged Populations age 65 or older- 1905(a)(iii) | | | | | |

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Citation | Condition or Requirement

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| Population | M | Geographic | V | Geographic | Excluded |
|---|---|---|---|---|---|
| SSI Related Groups Exempt from Mandatory Managed Care under 1932(a)(2)(B) | | | | | |
| Recipients Eligible for Medicare | | | | | |
| American Indian/Alaskan Natives | | | X | State- wide | AI/AN enrolled in managed care, AI/AN enrolled in Tribal ALTCS, AI/AN enrolled through Hospital Presumptive Eligibility, AI/AN enrolled in FFS Temporary, AI/AN enrolled in FFS Regular, AI/AN enrolled in Prior Quarter, and AI/AN enrolled in Federal Emergency Services Only. |
| Children under 19 who are eligible for SSI | | | | | |
| Children under 19 who are eligible under Section 1902(e)(3) | | | | | |
| Children under 19 in foster care or other in-home placement | | | | | |
| Children under 19 receiving services funded under section 501(a)(1)(D) of title V and in accordance with 42 CFR 438.50(d)(v) | | | | | |
| Other | | | | | |

2. **Excluded Groups.** Within the populations identified above as Mandatory or Voluntary, there may be certain groups of individuals who are excluded from the managed care program. Please indicate if any of the following groups are excluded from participating in the program:

☐ Other Insurance--Medicaid beneficiaries who have other health insurance.

**XX** Reside in Nursing Facility or ICF/MR--Medicaid beneficiaries who reside in Nursing Facilities (NF) or Intermediate Care Facilities for the Mentally Retarded (ICF/MR).

**XX** Enrolled in Another Managed Care Program--Medicaid beneficiaries who are enrolled in another Medicaid managed care program

| Citation | Condition or Requirement |
|---|---|

☐Eligibility Less Than 3 Months--Medicaid beneficiaries who would have less than three months of Medicaid eligibility remaining upon enrollment into the program.

☐Participate in HCBS Waiver--Medicaid beneficiaries who participate in a Home and Community Based Waiver (HCBS, also referred to as a 1915(c) waiver).

**XX** Retroactive Eligibility–Medicaid beneficiaries for the period of retroactive eligibility.

☐ Other (Please define):

1932(a)(4) F. Enrollment Process.

1. Definitions.

   a. Auto Assignment- assignment of a beneficiary to a health plan when the beneficiary has not had an opportunity to select their health plan.

   b. Default Assignment- assignment of a beneficiary to a health plan when the beneficiary has had an opportunity to select their health plan.

2. Please describe how the state effectuates the enrollment process. Select an enrollment methodology from the following options and describe the elements listed beneath it:

   a. **XX** The applicant is permitted to select a health plan at the time of application.

      i. How the state fulfills its obligations to provide information as specified in 42 CFR 438.10(e).
      *The AIMH PCCM program is a voluntary program. Individuals who elect to participate in the FFS American Indian Health Plan (AIHP) can select an AIMH site. Individuals can select an AIMH when they access a participating AIMH provider or by contacting AHCCCS. Selection forms will be available at AIMH sites and on the AHCCCS website and will be processed by AHCCCS on a monthly basis. Forms will be available both electronically and paper formats. The form will include the features and benefits of the program, the right to disenroll, and any other information required by federal and state regulations including 438.54(c)(3).*

      ii. What action the state takes if the applicant does not indicate a plan

iii. selection on the application.
*The AIMH PCCM program is a voluntary program. Individuals may select an AIMH provider at a later date through AHCCCS or by indicating participation through AIMH provider forms described above.*

iv. If action includes making a default assignment, describe the algorithm used and how it meets all of the requirements of 42 CFR 438.50(f).

| Citation | Condition or Requirement |
|---|---|

v. The state's process for notifying the beneficiary of the default assignment. (Example: *state generated correspondence*.)

b. ☐ The beneficiary has an active choice period following the eligibility determination.

i. How the beneficiary is notified of their initial choice period, including its duration.

ii. How the state fulfills its obligations to provide information as specified in 42 CFR 438.10(e).

iii. Describe the algorithm used for default assignment and describe the algorithm used and how it meets all of the requirements of 42 CFR 438.50(f).

iv. The state's process for notifying the beneficiary of the default assignment.

c. ☐ The beneficiary is auto-assigned to a health plan immediately upon being determined eligible.

i. How the state fulfills its obligations to provide information as specified in 42 CFR 438.10(e).

ii. The state's process for notifying the beneficiary of the auto-assignment. (*Example: state generated correspondence*.)

iii. Describe the algorithm used for auto-assignment and describe the algorithm used and how it meets all of the requirements of 42 CFR 438.50(f).

1932(a)(4)
42 CFR 438.50

3. State assurances on the enrollment process.

Place a check mark to affirm the state has met all of the applicable requirements of choice, enrollment, and re-enrollment.

a. ☐The state assures it has an enrollment system that allows Beneficiaries who are already enrolled to be given priority to continue that enrollment if the MCO

| Citation | Condition or Requirement |
|---|---|

or PCCM does not have capacity to accept all who are seeking enrollment under the program.

b. **XX** The state assures that, per the choice requirements in 42 CFR 438.52, Medicaid Beneficiaries enrolled in either an MCO or PCCM model will have a choice of at least two entities unless the area is considered rural as defined in 42 CFR 438.52(b)(3).

c. ☐ The state plan program applies the rural exception to choice requirements of 42 CFR 438.52(a) for MCOs and PCCMs in accordance with 42 CFR 438.52(b). Please list the impacted rural counties:

XX This provision is not applicable to this 1932 State Plan Amendment.

d. **XX** The state applies the automatic reenrollment provision in accordance with 42 CFR 438.56(g) if the recipient is disenrolled solely because he or she loses Medicaid eligibility for a period of 2 months or less.

☐This provision is not applicable to this 1932 State Plan Amendment.

1932(a)(4)
42 CFR 438.56

G. Disenrollment

1. The state will☐/**will not XX** limit disenrollment for managed care.
2. The disenrollment limitation will apply for months (up to 12 months).
3. **XX** The state assures that beneficiary requests for disenrollment (with and without cause) will be permitted in accordance with 42 CFR 438.56(c).
4. Describe the state's process for notifying the Medicaid Beneficiaries of their right to disenroll without cause during the first 90 days of their enrollment. *(Examples: state generated correspondence, HMO enrollment packets etc.)*
*The AIMH PCCM program is voluntary and includes no disenrollment limits. Individuals will be provided with information on selecting (enrolling) into an AIMH and information on disenrolling or selecting a different AIMH provider when they elect to participate in the FFS AIHP program.*

   *Additionally, information on disenrollment or selecting a new AIMH provider will be available at AIMH clinics as well as forms to initiate such disenrollment or selection of a new AIMH provider.*

5. Describe any additional circumstances of "cause" for disenrollment (if any).

H. Information Requirements for Beneficiaries

1932(a)(5)(c)
42 CFR 438.50
438.10(e)

**XX** The state assures that its state plan program is in compliance with 42 CFR 438.10 for information requirements specific to MCOs and PCCM programs operated under section 1932(a)(1)(A)(i) state plan amendments.

1932(a)(5)(D)(b)
1903(m)
1905(t)(3)

I. List all benefits for which the MCO is responsible.

*AIMH PCCMs will provide coordination and monitoring of state plan services including, in some instances, self-management techniques for Diabetes Management.*

*The State AIMH PCCM will offer four levels of AIMH based on the level of case management/care coordination offered. The levels of case management described in PCCM contract language are:*

*1) American Indian Medical Home*

*2) American Indian Medical Home, with diabetes education*

*3) American Indian Medial Home, and participates in the state Health Information Exchange*

*4) American Indian Medical Home, with diabetes education, and participates in the state Health Information Exchange*

*An AIMH which qualifies for the first level of the AIMH program will have achieved Patient Centered Medical Home recognition through NCQA, Accreditation Association for Ambulatory Health Care, The Joint Commission PCMH Accreditation Program, or other appropriate accreditation body, or an IHS IPC may attest annually that the site has completed the following in the past year:*

*a. Submitted the SNMHI Patient-Centered Medical Home Assessment (PCMH-A) to*

*IHS IPC;*

*b. Submitted monthly data on the IPC Core Measures to the IPC Data Portal; AND*

*c. Submitted narrative summaries on IPCMH improvement projects to IHS IPC*

*quarterly*

*This first level of AIMH would provide primary care case management services as well as 24 hour telephonic access to the care team.*

*The second level of AIMH would provide all of the services described in the first level as well as diabetes education. This level will require an AIMH to have a diabetes education accreditation through a recognized accreditation agency. The state will not prescribe to AIMH entities what must be included in these educational programs.*

*The third level of AIMH includes all the services described in the first level as well as participation in the state Health Information Exchange.*

*The fourth level of AIMH will provide all services described in the first three levels.*

*The AIMH program is not a shared savings or value based purchasing program. AIMH PCCM payments to qualified IHS or Tribal owned 638 facilities are on a prospective enrollment basis with no retroactive eligibility adjustment and claimable at the 100 percent FMAP rate.*

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1932(a)(5)(D)(b)(4)
42 CFR 438.228

J. ☐The state assures that each managed care organization has established an internal grievance procedure for enrollees.

1932(a)(5)(D)(b)(5)
42 CFR 438.206
42 CFR 438.207

K. Describe how the state has assured adequate capacity and services.

1932(a)(5)(D)(c)(1)(A)
42 CFR 438.240

L. ☐The state assures that a quality assessment and improvement strategy has been developed and implemented.

1932(a)(5)(D)(c)(2)(A)
42 CFR 438.350

M. ☐The state assures that an external independent review conducted by a qualified independent entity will be performed yearly.

1932 (a)(1)(A)(ii)

N. Selective Contracting Under a 1932 State Plan Option

To respond to items #1 and #2, place a check mark. The third item requires a brief narrative.

1. The state **will** **XX**/will not☐ intentionally limit the number of entities it contracts under a 1932 state plan option.

2. **XX** The state assures that if it limits the number of contracting entities, this limitation will not substantially impair beneficiary access to services.

3. Describe the criteria the state uses to limit the number of entities it contracts under a 1932 state plan option. *(Example: a limited number of providers and/or enrollees.)*

   *All AHCCCS registered IHS and tribal 638 facilities can participate in the AIMH PCCM program. In order to qualify as an AIMH and be eligible to receive a per member per month (PMPM) for empaneled members, providers must demonstrate annually that they have met the AIMH criteria described in the PCCM AIMH contract.*

   *Under 42 CFR 438.14, IHS and Tribal 638 organizations are able to limit enrollment in a PCCM to American Indian/Native Alaskan enrollees. The state will offer this AIMH PCCM program only to IHS and Tribal 638 organizations meeting contract requirements and offering enrollment in PCCM only to individuals selecting and participating in the FFS AIHP program.*

   *The State AIMH PCCM will offer four levels of PMPM payment based on the level of case management/care coordination offered. The levels of case management described in PCCM contract language are:*
   *1) American Indian Medical Home*
   *2) American Indian Medical Home, with diabetes education*

3) *American Indian Medial Home, and participates in the state Health Information Exchange*
4) *American Indian Medical Home, with diabetes education, and participates in the state Health Information Exchange*

4. ☐The selective contracting provision in not applicable to this state plan.