

AHCCCS PROGRAM UPDATE
1115 Waiver Renewal
Public Meeting
April 25, 2011

Monica Coury
Assistant Director
Office of Intergovernmental Relations

Background

- On February 15, the Secretary of the U.S. Department of Health and Human Services (HHS) informed Arizona that it could make changes to eligibility for those populations covered under its 1115 Waiver, which is set to expire September 30, 2011, and that these changes would not violate Maintenance of Effort (MOE) requirements under the Affordable Care Act (ACA).
- AHCCCS covers two populations under its 1115 Waiver – childless adults and Medical Expense Deduction.
- All other populations are covered under the State Plan. All states participating in Medicaid must have a State Plan, the details of which are prescribed by federal law.
- Those areas where the State deviates from federal law are found in the 1115 Waiver, which refers to Section 1115 of the Social Security Act. Section 1115 grants the Secretary of HHS broad authority to waive federal Medicaid rules for states.
- As part of the recent legislative budget discussions, the legislature passed language that requires the AHCCCS Administration to operate a Medicaid program within available resources.
- The following changes are being sought to meet the available appropriation, preserve coverage to the greatest extent possible and provide life-saving benefits.

Background

Proposition 204 Language

- Ballot language stated:
- “A ‘yes’ vote shall have the effect of providing funding for ... increasing healthcare coverage eligibility... using tobacco litigation settlement money”
- “A ‘no’ vote shall have the effect of not requiring appropriation of tobacco settlement money to support these programs.
- The ballot language also directed that the Tobacco Settlement monies shall be “supplemented, as necessary, by any other *available* sources and federal monies”
- The Legislature has based its authority to change eligibility because of a lack of other available resources.
- Ultimately, the courts would decide if litigated.

Medicaid Eligibility Reforms

- *Medical Expense Deduction (MED).*

- Individuals on the MED program are ineligible for AHCCCS because their income is too high but qualify for MED because they have incurred sufficient medical debt to put them at 40% of federal poverty level (FPL).
- MED is a time-limited program; eligibility is awarded for 3-6 months.
- Beginning May 1, 2011, freezes enrollment in the MED Program.
- Because eligibility is time limited, a May 1 freeze means that the eligibility period for all MED members would have naturally expired by October 1, 2011. Prompt federal approval is desired so that the State does not have to terminate coverage for individuals in the middle of their block of eligibility.
- All individuals currently enrolled will keep their coverage through the end of their eligibility period, assuming CMS approves the Phase Out Plan timely.
- The MED Phase Out Plan is on the AHCCCS website. All individuals in the MED program will be reviewed for eligibility in another AHCCCS eligibility category and all MED members will have the opportunity to provide information as to whether they have experienced a decrease in income to make them AHCCCS eligible.

Medicaid Eligibility Reforms

■ *Childless Adults.*

- Childless adults are individuals who have no categorical link to Medicaid – that is, they are not elderly, blind, disabled, pregnant, a child or a parent of a deprived child.
- Arizona covers childless adults through a special waiver.
- As of July 1, 2011, freezes enrollment for any new applicants.
- Revises current childless adult eligibility from an open-ended entitlement program to one based on available appropriations.
- Allows childless adults currently eligible to retain coverage.
- Proposes switching to six month redeterminations.
- Childless adult phase out plan is available on the AHCCCS website for public comment
- Phase Out Plan will move all SMIs, over age 65 and under age 65 with Medicare into a different eligibility category (SSI MAO).

Medicaid Eligibility Reforms

- *Childless Adults (cont.)*
 - Proposes instituting annual fees and incentive strategies to promote healthy behaviors.
 - The idea is to directly engage the consumer to take charge of those behaviors that are within their control and under a doctor's supervision – for instance, smoking or chronic disease management.
 - The annual fee only applies to childless adults – not the disabled or any individual for whom their doctor believes meeting the healthy behavior goal is not likely.
 - The State is pursuing incentive grants to combine with this strategy. The ACA incentive grant application is due in early May and will be made available on the AHCCCS website.
 - This is a high-level concept *only* that has been submitted to CMS for discussion. If CMS is amenable to a dialogue, the State will develop a specific operational model.
 - The strategy is taken from the model used by many Employers who have achieved positive wellness results by charging employees higher premiums for smoking or failure to adhere to wellness initiatives.
 - The ultimate goal is to stretch the health care dollar to maximize coverage to the greatest extent possible and preserve life-saving benefits.

Medicaid Eligibility Reforms

■ *Parents.*

- Parents are covered under Section 1931 of the Social Security Act. This eligibility category is sometimes referred to as TANF parents.
- Beginning October 1, 2011, the proposal would freeze enrollment for parents between 75-100% FPL.
- Parents currently enrolled will keep their coverage.
- The proposal also seeks to institute 6-month redeterminations.
- A waiver of the MOE provisions found in the ACA is required in order to implement this proposal.
- The State is currently developing a transition plan for this population, which will be made available for comment on the AHCCCS website.

Medicaid Eligibility Reforms

- *Eliminate Federal Emergency Services (FES).*
 - FES provides coverage for emergency services to those individuals who are otherwise Medicaid eligible but cannot meet the citizenship or non-qualified alien requirement.
 - The proposal would eliminate FES.
 - This proposal would require HHS to grant the State a waiver of MOE requirements.

Personal Responsibility Reforms

- *Copayments.*
 - All parents and children would be required to pay mandatory copayments.
 - Currently, as per federal law, these populations are only subject to nominal copayments and services cannot be denied for failure to pay a copayment.
 - This request requires a waiver because current federal regulations do not permit charging mandatory copayments to parents and children.
 - The rationale is to stretch the State's health care dollar to permit the State to maximize coverage to the greatest extent and preserve coverage for life-saving benefits.
 - California is seeking a similar waiver.
 - American Indians are exempt from these cost sharing requirements.

Personal Responsibility Reforms

- *Copayments (cont.)*
 - *There are two types of copayment amounts the State is seeking.*
 - *The first set of dollar amounts for copayment requirements is the suggested amount in the Governor's reform plan and are as follows:*
 - *Prescriptions: \$2.30.*
 - *Doctor/provider outpatient office visits for evaluation and management: \$4.00.*
 - *Physical, Occupational and Speech Therapies: \$3.00.*
 - *Outpatient Non-emergency or voluntary surgical procedures: \$3.00*

Personal Responsibility Reforms

- ***Copayments (cont.)***
 - ***The second set of dollar amounts for copayment/premium requirements are prescribed in the Budget Reconciliation Bill as set forth by the legislature and are as follows:***
 - A monthly premium of \$15, except that the total monthly premium for an entire household shall not exceed \$60.
 - Physician office: \$5 for each visit.
 - Urgent care: \$10 for each visit.
 - Emergency department : \$30 for each visit.
 - ***(see Laws 2011, Chapter 31, Section 11)***

Personal Responsibility Reforms

- ***Penalty for Missed Appointments.***
 - This would permit health care providers to charge AHCCCS members a \$25 fee, as set by the legislature, for missing a scheduled appointment.
 - The fee would be collected by the provider, not by the AHCCCS Administration.
 - This is designed to serve as a tool for providers to manage their appointment calendars.

Benefit Reforms

- ***Restore Transplants Previously Eliminated.***
(Effective 4/1/11.)
- ***New Benefit Limits.***
 - The agency is reviewing new benefit limits, including:
 - 25-day hospital inpatient limit for adults;
 - 12-day emergency department limits; and
 - The agency is reviewing the reduction of the total number of respite hours for caregivers of persons with developmental disabilities.
(Current allowable is 720 hours.)
 - The goal is to be able to spread reductions across the board so that the State can maximize coverage to the greatest extent possible and preserve life-saving benefits.

Benefit Reforms

- ***Non-Emergency Medical Transportation.***

- There are two different transportation requests. The first is part of the Governor's Reform Plan and requests the following:

- The agency is seeking authority to eliminate non-emergency transportation for all parents and childless adults in Maricopa and Pima counties and require a copay in all other counties.
- Non-emergency medical transportation provided by I.H.S. and 638s is 100% federally funded and would be part of the cost shift avoidance waiver request (see end of slides).

- The second request was part of the budget where the legislature amended A.R.S. 36-2907 (G), which reads as follows:

- G. The director shall adopt rules for the provision of transportation services and rules providing for copayment by members for transportation for other than emergency purposes. Subject to approval by the centers for medicare and medicaid services, nonemergency medical transportation shall not be provided to persons who are eligible pursuant to sections 36-2901.01 and 36-2901.04 and who reside in a county with a population of more than five hundred thousand persons except FOR STRETCHER VANS AND AMBULANCE TRANSPORTATION. PRIOR AUTHORIZATION IS REQUIRED FOR TRANSPORTATION BY STRETCHER VAN AND FOR MEDICALLY NECESSARY AMBULANCE TRANSPORTATION INITIATED PURSUANT TO A PHYSICIAN'S DIRECTION. Prior authorization is not required for medically necessary ambulance transportation services rendered to members or eligible persons initiated by dialing telephone number 911 or other designated emergency response systems.

Payment and Other Reforms

- ***Innovations in Medicaid.***

- The proposal seeks to reform the way Medicaid pays for health care services to move away from paying for quantity of services provided to a model that reimburses for quality of the care that is provided.
- The goal is to incentivize providers to reduce hospital admissions and focus of quality of care by allowing providers to share in savings achieved.
- These concepts are in line with ideas in the Affordable Care Act and Patient Centered Medical Homes and Affordable Care Organizations.

Payment and Other Reforms

- *Cost Effectiveness Reimbursement for the DD Program.*
 - This would allow the agency to set the cost of home and community based services provided to members within the DD program based on a comparison of the cost of care in the member's own home or an appropriate alternative out-of-home placement, rather than to an ICF-MR since the DD program has been largely de-institutionalized. (99% of all DDD members reside in the home or community.)
 - This would allow for a more equitable distribution of resources to ensure preservation of coverage to the greatest extent possible.

Payment and Other Reforms

- ***Reduce Provider Payments.***
 - The proposal reduces provider and managed care organization rates by 5%.
 - Also, eliminates outlier payments.
 - These are State Plan Amendments and not waiver requests.

Payment and Other Reforms

- ***Seek Reimbursement of Medicare Liability.***
 - The Agency seeks reimbursement of services paid for those individuals who should have been Medicare eligible but were not because of errors at the Social Security Administration.
 - The Social Security Administration has acknowledged and corrected this error.
 - It is estimated that the State is owed about \$40 million.

Avoid Cost Shift to Indian Health Services and 638 Facilities

- ***Protect Indian Health Services and 638 Facilities.***
 - Arizona provides care for qualified American Indians who receive services at the Indian Health Services (IHS) or 638 facilities with 100% Federal dollars.
 - The proposal seeks federal authority to exempt benefit restrictions and eligibility changes for those services and benefits obtained through I.H.S. 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.
- ***Tribal Participation.*** AHCCCS encourages tribes to support this carve out to protect the IHS and 638 facilities from these changes.