

AHCCCS Activities Affordable Care Act

On March 23, 2010, the President signed into law the Patient Protection and Affordable Care Act (ACA). The ACA includes multiple provisions that significantly impact the Medicaid program. Information regarding AHCCCS implementation of these provisions is provided below.

Drug Rebates (§ 2501; Effective 3/23/2010)

Extends drug rebates to managed care and increases the rebate amount drug manufacturers are required to pay under the Medicaid drug rebate program.

- *AHCCCS Progress:* On January 26, 2010, CMS approved State Plan Amendment (SPA) #10-007 so Arizona can collect rebates for drugs dispensed under managed care and fee-for-service. AHCCCS awarded a contract to Provider Synergies, a division of Magellan Health Services, Inc.¹, to implement the drug rebate program according to guidelines from CMS and required timelines. AHCCCS, through the work of the contractor, began processing rebates in the Spring of 2011. The vast majority of funds will be transferred to the federal government but some portion will be returned to the General Fund. AHCCCS estimates that rebate contributions to the General Fund will be less than \$20 million annually.

Federal Coverage and Payment Coordination for Duals (§§ 2602 and 3021)

Creates a new federal office to integrate Medicare and Medicaid more effectively and improve access to and quality of care for dual eligible members. Broad new waiver authority has been provided to the Center for Medicare and Medicaid Innovation.

- *AHCCCS Progress:* With roughly one-third of the 100,000 AHCCCS dual eligible members enrolled in the same plan for both Medicaid and Medicare, AHCCCS has been a national leader in improving care coordination for this population. AHCCCS continues to evaluate and identify any opportunities that might exist for future efficiencies and coordination with CMS. CMS recently announced an opportunity through the Center for Medicare and Medicaid Innovation to develop new demonstrations to improve services for dual eligible members. AHCCCS submitted a proposal to CMS on February 10, 2011, for up to \$1.0 million in technical contract support. AHCCCS was not one of the 15 states to receive the CMS support, however the Agency will continue to work with the Federal Coordinated Health Care Office (Office of the Duals) at CMS in an effort to increase alignment and improve service delivery to dual eligible members. More information can be found at: <http://www.azahcccs.gov/reporting/Downloads/HealthCareReform/DualsIntegratedCareProposal.pdf>

Health Homes for Enrollees with Chronic Conditions (§ 2703)

Provides \$25M to the Secretary of Health and Human Services in planning grants for states to create a new Medicaid state plan option to permit enrollees with at least two chronic conditions, or one condition and being at risk of developing another, or at least one serious and persistent mental health condition, to designate a provider as a health home.

1. *AHCCCS Progress:* CMS has issued preliminary guidance on the implementation of this section of the ACA. On March 29, 2011, CMS approved Arizona's planning request. As detailed in the request, Arizona is interested in determining the feasibility of developing integrated health homes for persons with Serious Mental Illness.
- AHCCCS will work with the Arizona Department of Health Services, Division of Behavioral Health, to review potential options for the Seriously Mentally Ill population. On May 2, 2011, AHCCCS submitted its proposal. More information can be found at: <http://www.azahcccs.gov/reporting/federal/legislation.aspx#healthhomes>

¹ The contract between AHCCCS and Provider Synergies requires that Provider Synergies segregate all information received under the contract from all other business units of Magellan Health Services.

Health Insurance Exchanges (§ 2201; Effective 1/1/2014)

Requires Exchanges for individuals and small businesses to compare, select and pay for health care plans. Individuals will also be able to apply for and renew eligibility for Medicaid and tax subsidies.

- AHCCCS Progress: On September 30, 2010, the Governor's Office received \$1 million for planning the development of the Exchange, which will involve stakeholders. While it is anticipated AHCCCS will not run the Exchange, federal law requires that the Medicaid program be able to interface with the Exchange for eligibility determinations. AHCCCS has presented information to the Office of the National Coordinator regarding Health-e-Arizona and other eligibility efforts that leverage technology. AHCCCS has engaged the services of a contractor to evaluate the current eligibility infrastructure and to conduct a gap analysis between existing capabilities and the new requirements that must be implemented for an Exchange either at the State or federal level. The gap analysis is underway with an anticipated completion date of sometime in May 2011.
- Impact to Health Care Group (HCG): The impact and future of HCG will remain a policy decision for the Legislature that should be discussed as part of any debate on the establishment of the Exchange.

Health Insurance Market Reforms (§§ 1201-1255; Effective 3/23/10)

- 1) Allows Employer Groups to remain enrolled in Classic and Active plans as of March 23, 2010, and be "grandfathered" into those plans, provided they do not switch to another plan.
 - HCG Progress: HCG has "grandfathered" all Employer Groups into the plans they were enrolled as of March 23, 2010. Employer Groups which were enrolled in Classic or Active plans between March 23 and December 31, 2010, are not "grandfathered" and will have to enroll in "non-grandfathered" Copper and Silver plans at their next enrollment.
- 2) Requires Employer Groups enrolled after December 31, 2010, to enroll into the "non-grandfathered" Copper and Silver plans which contain the recommended preventive services not subject to deductibles or copays.
 - HCG Progress: HCG created two new product lines, Copper and Silver Plans, with an effective date of 1/1/2011, which contain Categories A and B of the USPSTF recommended preventive services, and are not subject to deductibles or copays.
- 3) Requires all "grandfathered" and "non-grandfathered" plans to include provisions which: 1) allow adult dependents of Members up to age 26 to enroll in HCG if they are not eligible for employer-sponsored coverage; 2) prohibit imposition of pre-existing condition exclusions for Members under age 19; 3) eliminate annual and lifetime limits on the dollar amount of benefits; and 4) prohibit rescissions of coverage except for intentional misrepresentation or fraud.
 - HCG Progress: HCG has revised all plans to include these provisions.

Healthcare Acquired Conditions (§ 2702; Effective 7/1/2011)

Prohibits federal payments for Medicaid services related to healthcare acquired conditions (HACs).

- AHCCCS Progress: AHCCCS is developing policy related to the list of conditions and preventable surgical errors that could result in non-payment by Medicaid. AHCCCS contractors will be expected to follow this policy as they review and process medical claims. System and regulatory changes will be initiated as necessary.

Maintenance of Eligibility (MOE) Requirements (§2001; Eff. 3/23/2010)

Requires states to maintain eligibility levels in effect on the date of the ACA's enactment. For Arizona, this means that the eligibility standards, methodologies, and procedures in place on July 1, 2008, (due to the ARRA MOE) must remain in effect for Title XIX Medicaid and Title XXI Children's Health Insurance Program (CHIP) until January 1, 2014, for adults, and until September 30, 2019, for children as a condition for receiving any federal payments.

→ *AHCCCS Status:* The Governor's FY 2012 Budget includes the recommendation that AHCCCS pursue a waiver of the MOE requirements. Since the provision in the ACA is under §1902 of the Social Security Act, it is a waivable provision the Secretary has authority to grant. The Governor was also part of a group of 33 Governors requesting the Congress to amend the ACA language to allow states some flexibility on the MOE provisions. AHCCCS submitted the Waiver request to CMS on January 25, 2011. On February 15, 2011, Secretary Sebelius outlined steps Arizona could take to manage its Medicaid program and balance its budget without violating MOE requirements and on March 31, 2011, AHCCCS revised its waiver submittal. The MOE Waiver is still pending before CMS. More information can be found at: <http://www.azahcccs.gov/reporting/legislation/proposals.aspx#MOE>

National Correct Coding Initiative (CCI) (§ 6507 Eff. 10/1/2010)

Requires State Medicaid programs to have CCI edits in place for the purposes of processing claims

→ *AHCCCS Progress:* AHCCCS instituted a number of the CCI edits several years ago, incorporating them as a requirement in its health plan contracts. Several of the limits established by AHCCCS appear to exceed the limits established by CMS and staff is working with CMS to resolve any outstanding issues.

New Options to Provide Long-Term Services and Supports (§§ 2401-2403)

Community First Choice Option (§2401; Eff. 10/1/2011):

Allows states to provide community-based attendant supports and services to individuals with disabilities who require an institutional level of care at a 6% enhanced Federal match.

→ *AHCCCS Progress:* A consumer-directed Council is being established to assist in enhancing the utilization of consumer controlled home and community-based attendant supports and services. CMS issued a proposed rule on February 25, 2011, describing the option and how additional match can be claimed for managed care programs.

Removal of Barriers to Providing HCBS (§2402; Eff. 10/1/2010)

Allows states to provide home and community based services (HCBS) under the State Plan for individuals with incomes up to 300%.

→ *AHCCCS Status:* AHCCCS will not pursue this option since, via its §1115 Waiver, it currently provides HCBS for qualified individuals who require an institutional level of care. The State Plan option would expand coverage to those not at risk of institutionalization.

Money Follows the Person (§2403; Eff. 3/23/10)

Extends the program until September 30, 2016, and changes eligibility by requiring individuals to reside in an inpatient facility for at least 90 days (previously 180 days).

→ *AHCCCS Progress:* AHCCCS will not pursue the Money Follows the Person program. Over 80% of those in Arizona's Long Term Care program already reside in the community. Based on an analysis of members that would meet the criteria for enhanced match under the program, the benefit to the State would be less than \$300,000. Administrative requirements associated with the program would have resulted in a higher administrative burden to manage.

Prohibition on Payments to Non U.S. Entities (§6505; Eff. 1/1/2011)

Prohibits states from making any payments for items or services provided under a Medicaid State Plan or waiver to any financial institution or entity located outside the U.S.

- *AHCCCS Status:* AHCCCS is in compliance with the federal requirement prohibiting the single State Agency from making payments for medical assistance to financial institutions and billing entities located outside the U.S. SPA #11-003 was approved by CMS on March 31, 2011, updating Arizona's State Plan with the attestation that it meets the requirement.

Provider Screening (§6401; Eff. 3/25/2011)

Requires program integrity changes that include: background screening of providers based on risk category; imposition of application fees for institutional providers to cover screening costs; imposition of moratoria on high-risk providers; suspension of payments based on credible allegation of fraud; reporting and documentation retention requirements on behalf of the State.

- *AHCCCS Status:* AHCCCS is in the process of reviewing the final rule which was published on January 24, 2011. Existing mechanisms are in place to prevent providers from registering that have been excluded from Medicare/Medicaid programs. Staff is currently working on evaluating processes needed to implement additional requirements in the final rule.

Quality Demonstration and Grant Opportunities (§2703-2705; Eff. 1/1/2011 or 1/1/2012)

Provides competitive demonstration and grant opportunities for states to develop payment structures to reimburse for care coordination, including care management and health promotion, and integrated care during a hospitalization.

- *AHCCCS Status:* AHCCCS will not pursue these options since it will request demonstration authority under its §1115 waiver for greater flexibility with innovative reimbursement methodologies that will meet or exceed the desired outcomes provided for in these sections of the ACA's demonstration opportunities.

Recovery Audit Contractors (RAC) (§ 6411; Required by 12/31/2010)

Requires that states name a RAC to identify underpayments and overpayments and recover overpayments for services paid by Medicaid. RAC requirements are based on a fee-for-service structure model of healthcare delivery similar to that of Medicare.

- *AHCCCS Progress:* AHCCCS has implemented a [Program Integrity Plan](#) to promote economy, efficiency, accountability, and integrity in the management and delivery of services throughout the Agency. AHCCCS submitted SPA #10-012 to CMS to be in compliance with this requirement and on March 1, 2011 CMS approved the SPA, which establishes the use of a Statewide RAC to identify and recover overpayments. An exception related to underpayments allows AHCCCS 12 months to add identification of underpayments to the process.