



**Arizona Section 1115 Waiver
Amendment Request:
Proposal to Waive Prior
Quarter Coverage**

April 6, 2018



Table of Contents

SUMMARY	1
OVERVIEW	1
PROPOSED DEMONSTRATION CHANGES & WAIVER AUTHORITIES	2
A. PROPOSED CHANGES TO ELIGIBILITY REQUIREMENTS UNDER THE DEMONSTRATION AS AMENDED.....	2
B. PROPOSED COST SHARING REQUIREMENTS UNDER THE DEMONSTRATION AS AMENDED.....	2
C. PROPOSED CHANGES TO THE DELIVERY SYSTEM UNDER THE DEMONSTRATION AS AMENDED.....	2
D. PROPOSED CHANGES TO BENEFIT COVERAGE UNDER THE DEMONSTRATION AS AMENDED.....	2
E. WAIVER AND EXPENDITURE AUTHORITIES NECESSARY TO AUTHORIZE THE DEMONSTRATION.....	3
CHIP ALLOTMENT	3
EVALUATION DESIGN	3
PUBLIC PROCESS	4
A. PUBLIC WEBSITE.....	4
B. STAKEHOLDER MEETINGS.....	4
C. SUMMARY OF PUBLIC COMMENTS.....	4
APPENDICES	7
APPENDIX 1: BUDGET NEUTRALITY	
APPENDIX 2: TRIBAL CONSULTATION	
APPENDIX 3: PUBLIC FORUMS PRESENTATION SLIDES	
APPENDIX 4: PUBLIC COMMENT LETTERS	

Arizona Section 1115 Waiver Amendment Request Proposal to Waive Prior Quarter Coverage

SUMMARY

The Arizona Health Care Cost Containment System (AHCCCS) is requesting a waiver of the federal requirement to provide individuals applying for Title XIX coverage up to three months of retroactive eligibility coverage prior to the month of application. AHCCCS is seeking the flexibility to limit retroactive coverage to the month of application, consistent with Arizona's historical waiver authority prior to January 2014.

Accordingly, AHCCCS is requesting that the Centers for Medicare and Medicaid Services (CMS) waive Section 1902(a)(34) and 42 CFR 435.915 to the extent necessary to enable the State to refrain from providing eligibility for any month prior to the month in which the member's Medicaid application was filed.

OVERVIEW

Under current authority, if an individual applying for AHCCCS qualifies for AHCCCS eligibility during any portion of three months immediately preceding the month in which the member applied for AHCCCS coverage, AHCCCS is required to reimburse providers for any AHCCCS-covered service received by the member during that period.¹

AHCCCS is seeking the flexibility to limit retroactive coverage to the month of application, consistent with Arizona's historical waiver authority prior to January 2014. Under the proposed waiver amendment, individuals applying for Title XIX eligibility would continue to receive retroactive coverage effective as of the first day of the month in which the Medicaid application was filed.

This proposal to waive Prior Quarter Coverage eligibility promotes the objectives of the Medicaid program by (1) encouraging members to obtain and continuously maintain health coverage, even when healthy; (2) encouraging members to apply for Medicaid without delays to promote continuity of eligibility and enrollment for improved health status; and (3) containing Medicaid costs. These objectives support the sustainability of the Medicaid program and more efficiently focus resources on providing accessible and high quality health care while limiting the resource-intensive process associated with prior quarter coverage eligibility. Arizona will educate the community regarding this change.

¹ Social Security Act Section 1902(a)(34); 42 CFR 435.915.

PROPOSED DEMONSTRATION CHANGES & WAIVER AUTHORITIES

A. Proposed Changes to Eligibility Requirements under the Demonstration as Amended.

The eligibility requirements for persons impacted by this proposed demonstration amendment will not vary from the State’s current program features as described in the current State Plan and Demonstration.

The table below shows AHCCCS enrollment figures for state fiscal years (SFY) 2016, 2017 and 2018. If this proposed demonstration amendment is implemented, there will be no impacts on prospective enrollment or on prior period coverage.²

Average Enrollment, SFY 2016	Average Enrollment, SFY 2017	Enrollment as of 03/01/2018
1,822,111	1,904,684	1,845,478

B. Proposed Cost Sharing Requirements under the Demonstration as Amended.

The cost sharing requirements for persons impacted by this proposed demonstration amendment will not change from the State’s current program features as described in the current State Plan and Demonstration.

C. Proposed Changes to the Delivery System under the Demonstration as Amended.

The delivery system for persons impacted by this proposed demonstration amendment will not vary from the State’s current program features as described in the current State Plan and Demonstration.

D. Proposed Changes to Benefit Coverage under the Demonstration as Amended.

Arizona is proposing to limit retroactive coverage to the month of application for Title XIX AHCCCS members. Since its implementation in 2014, the Prior Quarter Coverage eligibility requirement has resulted in a cost of \$69,955,595 (total funds). Implementing this proposal would result in an estimated savings of \$39,431,100 (total funds) in state fiscal year (SFY) 2019.

Table 1: Prior Quarter Coverage Historical Expenditures

State Fiscal Year	Total Funds
2014	\$19,809
2015	\$15,743,139
2016	\$21,708,207
2017	\$21,347,704
2018 ³	\$11,136,736
Total	\$69,955,595

² Prior Period Coverage refers to the time frame from the effective date of AHCCCS eligibility (first day of the month of application) until the date the member is enrolled with the Contractor.

³ SFY 2018 includes Prior Quarter Coverage expenditures from July 1, 2017 to November 30, 2017.

E. Waiver and Expenditure Authorities Necessary to Authorize the Demonstration.

Arizona respectfully requests that the CMS waive Section 1902(a)(34) and 42 CFR 435.915 to the extent necessary to enable the State not to provide medical coverage for any month prior to the month in which the member’s Medicaid application was filed.

CHIP ALLOTMENT

Not applicable. The amendment does not impact the Title XXI population.

EVALUATION DESIGN

Arizona’s 1115 Waiver Evaluation design will be modified to incorporate the Prior Quarter Coverage waiver amendment. The table below outlines the proposed hypotheses for this waiver amendment and potential performance measures that would allow AHCCCS to effectively test each of the specific hypotheses.

Proposed Hypotheses	Proposed Performance Measures
The implementation of the proposal will not adversely affect access to care.	<ul style="list-style-type: none"> • The number and percentage of adults and children who had an annual visit with a primary care physician (PCP) measured during the baseline year and annually thereafter. • The number and percentage of members utilizing specialty services measured during the baseline year and annually thereafter. • The number and percentage of members utilizing skilled nursing facilities measured during the baseline year and annually thereafter.
The implementation of the proposal will not result in reduced member satisfaction.	<ul style="list-style-type: none"> • Members’ satisfaction with overall health care experience, getting needed care, and getting care quickly as defined by the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) Health Plan Survey assessment measured during the baseline year and one year during the demonstration.
The implementation of the proposal will generate cost savings over the term of the waiver.	<ul style="list-style-type: none"> • The number of members who received Prior Quarter Coverage and the total funds expended on Prior Quarter Coverage measured during the baseline year and annually thereafter.

PUBLIC PROCESS

Pursuant to the Special Terms and Conditions (STC) that govern Arizona’s 1115 Waiver, Arizona must provide documentation of its compliance with the Demonstration of Public Notice process (42 CFR §431.408), as well as document that the tribal consultation requirements outlined in STC 15 have been met. This section of the document provides a summary of the public notice and input process used by AHCCCS to solicit feedback for this Proposal to Waive Prior Quarter Coverage.

Public Website

The amendment request was posted on the AHCCCS website for public comment on January 11, 2018, and can be found here: <https://www.azahcccs.gov/Resources/Federal/PendingWaivers/priorquartercoveragewaiveramendment.html>. The web page includes a summary of the proposal to waive Prior Quarter Coverage, the schedule (locations, dates, and times) of public forums across the state, this draft proposal to waive Prior Quarter Coverage, and budget neutrality worksheets. In addition to the website posting, AHCCCS used its Twitter account and electronic mail to notify interested parties about this proposal.

Stakeholder Meetings

AHCCCS presented the details about this proposal in a tribal consultation meeting on January 11, 2018 (Appendix 2). The Agency conducted public forum meetings on January 18th in Flagstaff, on January 26th in Phoenix, and on January 29th in Tucson. In addition, the proposal to waive Prior Quarter Coverage was presented at the State Medicaid Advisory Committee (SMAC) meeting on February 7, 2018. The public forum meetings included telephonic conference capabilities that ensured statewide accessibility. The presentation slides and other items from the stakeholder meetings are included in Appendix 3.

Summary of Public Comments

AHCCCS acknowledged, reviewed, and considered all comments received as part of the public input process. Feedback regarding this proposal to waive Prior Quarter Coverage was solicited from the audience at the public forum meetings. In addition, AHCCCS received approximately thirty comment letters from stakeholders including hospital associations, consumer advocacy groups, members, and providers (Appendix 4). Below is a summary of the comments received from stakeholders during the public input process.

Theme	Summary	State Response
Hospitals, Skilled Nursing Facilities and Other Health Care Providers - Uncompensated Care	Stakeholders expressed concern that a waiver of Prior Quarter Coverage could increase uncompensated care costs for hospitals, skilled nursing facilities and other health care providers.	AHCCCS appreciates the input offered by hospitals, skilled nursing facilities and other health care providers. AHCCCS is committed to ensuring ongoing access to care and will continue to monitor the stability of provider networks following implementation of the waiver.

Theme	Summary	State Response
Member Financial Burden & Disruptions in Care	Stakeholders expressed concern that the proposal to waive Prior Quarter Coverage will shift health care costs, resulting in increased out-of-pocket spending, medical bankruptcies and uncompensated care. Particular concern was expressed in regard to potential disruptions in care for individuals with complex medical conditions.	AHCCCS anticipates that the policy, offering retroactive coverage effective as of the first day of the month in which the Medicaid application was filed, will encourage members to obtain and maintain coverage regardless of health status and will incentivize providers and members to ensure Medicaid applications are completed expeditiously.
Timely Eligibility Determinations	Stakeholders expressed concern that AHCCCS has failed to address, in its waiver amendment proposal, how eligibility determinations would be made in a timely manner.	Retroactive coverage is based on the date of application. While the timely determination of eligibility determination is important, retroactive eligibility coverage beginning with the first day of the month of application is not affected by the date of eligibility determination.
American Indians	Stakeholders requested that American Indians be excluded from the proposal to waive Prior Quarter Coverage.	AHCCCS appreciates the commentary provided. AHCCCS' waiver amendment seeks to return to the Agency's historical waiver authority that allowed retroactive coverage effective as of the first day of the month in which the Medicaid application was filed with no exemptions.
Member Education and Outreach	While stakeholders expressed appreciation for the state's commitment to educating and encouraging Arizona residents to apply for AHCCCS coverage, they noted the absence of a specific plan for outreach in the proposal. Stakeholders recommended that AHCCCS conduct an aggressive community education and outreach program in conjunction with the waiver request and corresponding policy change.	AHCCCS appreciates the commentary provided. AHCCCS is developing an outreach and education strategy. Details regarding that strategy will be available on our website and through social media.

Theme	Summary	State Response
Misalignment with Medicaid Program's Objectives	Stakeholders asserted that the proposal to waive Prior Quarter Coverage will impede rather than promote the objectives of the Medicaid program by creating unnecessary barriers to enrollment and access to care.	The proposal to waive Prior Quarter Coverage promotes the objectives of the Medicaid program by encouraging beneficiaries to obtain and maintain health coverage, regardless of health status or needs. Furthermore, a waiver from this requirement will promote efficiency and the sustainability of the Medicaid program, allowing resources to be focused on providing accessible and high quality health care.
1115 Waiver Demonstration Evaluation	Stakeholders expressed concern that AHCCCS has not provided hypotheses or methods to test whether limiting retroactive coverage will achieve the objectives stated in the waiver application.	Please see the hypotheses and methods proposed in this waiver amendment.
Prior Quarter Coverage Data Request	Stakeholders requested a fiscal impact analysis of the PQC waiver amendment on hospitals and other providers serving the state's Medicaid population.	The proposal to waive Prior Quarter Coverage would result in an estimated savings of \$39,431,100 (total funds) in state fiscal year (SFY) 2019. Provider level data can be supplied upon request.
Phase-Out Approach	Stakeholders recommended that AHCCCS consider instituting a phase-out approach if granted approval to waive PQC, allowing time to build awareness, plan for changes and help mitigate potential adverse impacts to members and providers.	AHCCCS' waiver amendment seeks to return to the retroactive coverage requirement that was in effect prior to January 1, 2014 consistent with the former Waiver. It is not operationally feasible to implement a phase-out approach.

Theme	Summary	State Response
<p>Date of First Application</p>	<p>Stakeholders requested that the retroactive coverage period start from the point of the first application for coverage, not from the date of subsequent applications for coverage that had to be submitted because a previous application was denied.</p>	<p>AHCCCS appreciates the recommendation. If the initial application was denied in error, the date of the initial application is used for the purposes of retroactive coverage. In addition, if an Arizona Long Term Care System (ALTCS) application is denied but the application is complete, AHCCCS will ask the applicant if they would like to be considered for coverage through our acute program. If so, and if that acute application is approved, retroactive coverage will date back to the ALTCS application date. Otherwise, AHCCCS will not provide coverage back to the date of the first application.</p>

APPENDICES

Attached are the following appendices: (1) Budget Neutrality, (2) Tribal Consultation, (3) Public Forums Presentation Slides; and (4) Public Comment Letters.

APPENDIX 1: BUDGET NEUTRALITY



Arizona Health Care Cost Containment System
Budget Neutrality Status by Federal Fiscal Year
Total Funds - All Populations
For the Period October 1, 2011 - September 30, 2016
Updated 9-7-16

	Actual 2012 DY 1	Actual 2013 DY 2	Actual 2014 DY 3	Actual 2015 DY 4	Estimate 2016 DY 5	Total
Without Waiver Expenditure Limit Calculation						
Member Months						
TANF/SOBRA	11,705,994	11,625,194	11,801,894	12,550,433	13,072,034	60,755,549
SSI	1,957,010	1,994,523	2,070,897	2,161,363	2,179,302	10,363,095
AC	1,633,495	969,125	206,508	-	-	2,809,128
ALTCS-EPD	343,173	346,304	353,636	359,799	357,450	1,760,362
ALTCS-DD	294,483	307,446	320,971	337,018	349,744	1,609,662
Family Planning Extension	50,024	55,971	14,885	-	-	120,880
Expansion State Adults	-	-	1,825,873	3,370,318	3,719,427	8,915,618
Combined	15,984,179	15,298,563	16,594,664	18,778,931	19,677,958	86,334,295
Without Waiver PMPM						
TANF/SOBRA	585.28	615.71	647.73	681.41	716.85	651.40
SSI	885.41	938.53	994.84	1,054.53	1,117.81	1,001.65
AC	562.32	601.19	596.43	-	-	578.24
ALTCS-EPD	4,737.37	4,983.71	5,242.86	5,515.49	5,802.30	5,262.66
ALTCS-DD	4,922.38	5,217.72	5,530.78	5,862.63	6,214.39	5,577.69
Family Planning Extension	16.60	18.01	13.17	-	-	16.83
Expansion State Adults	-	-	622.04	588.94	603.75	601.90
Weighted	786.95	846.05	879.38	893.37	929.96	870.93
Without Waiver Expenditure Limit						
TANF/SOBRA	6,851,280,422	7,157,797,295	7,644,456,886	8,552,033,145	9,370,647,158	39,576,214,907
SSI	1,732,751,136	1,871,923,349	2,060,218,947	2,279,231,591	2,436,038,078	10,380,163,101
AC	918,546,622	582,623,717	123,166,560	-	-	1,624,336,899
ALTCS-EPD	1,625,736,418	1,725,878,708	1,854,065,072	1,984,468,431	2,074,028,358	9,264,176,987
ALTCS-DD	1,449,555,757	1,604,166,375	1,775,220,164	1,975,810,955	2,173,444,950	8,978,198,201
Family Planning Extension	830,631	1,008,110	195,976	-	-	2,034,717
Expansion State Adults	-	-	1,135,769,554	1,984,903,939	2,245,604,812	5,366,278,305
Total	12,578,700,986	12,943,397,553	14,593,093,159	16,776,448,061	18,299,763,356	75,191,403,116
DSH Allotment	154,369,963	161,973,765	160,613,022	160,250,974	159,658,938	796,866,663
Total Without Waiver Expenditure Limi	12,733,070,949	13,105,371,319	14,753,706,181	16,936,699,036	18,459,422,294	75,988,269,779
With Waiver Expenditures						
TANF/SOBRA	3,415,789,172	3,586,504,387	3,527,885,273	3,588,001,163	3,982,320,064	18,100,500,059
SSI	1,349,590,806	1,427,969,861	1,538,667,090	1,715,172,037	1,752,687,570	7,784,087,364
AC	918,546,622	582,623,717	123,166,560	-	-	1,624,336,899
ALTCS-EPD	1,062,183,658	1,167,575,274	1,196,152,014	1,245,896,337	1,267,554,522	5,939,361,805
ALTCS-DD	939,086,691	1,005,675,270	1,067,615,389	1,170,344,447	1,240,529,766	5,423,251,563
Family Planning Extension	830,631	1,008,110	195,976	-	-	2,034,717
Expansion State Adults	-	-	1,135,769,554	1,984,903,939	2,245,604,812	5,366,278,305
AI/AN Uncompensated Car	22,866,717	97,192,513	53,888,765	13,437,080	5,038,840	192,423,915
SNCP/DSHP	296,636,120	558,334,298	240,250,917	119,071,612	99,320,126	1,313,613,073
Expenditure Subtotal	8,005,530,417	8,426,883,430	8,883,591,538	9,836,826,615	10,593,055,700	45,745,887,700
DSH	155,762,651	163,493,529	162,262,955	160,244,372	159,658,938	801,422,445
Total With Waiver Expenditures	8,161,293,068	8,590,376,959	9,045,854,493	9,997,070,987	10,752,714,638	46,547,310,145
With Waiver Expenditure PMPMs						
TANF/SOBRA	291.80	308.51	298.93	285.89	304.64	
SSI	689.62	715.95	743.00	793.56	804.24	
AC	562.32	601.19	596.43	-	-	
ALTCS-EPD	3,095.18	3,371.53	3,382.44	3,462.76	3,546.11	
ALTCS-DD	3,188.93	3,271.06	3,326.21	3,472.65	3,546.96	
Family Planning Extension	16.60	18.01	13.17	-	-	
Expansion State Adults	-	-	622.04	588.94	603.75	
Budget Neutrality Variance	4,571,777,881	4,514,994,360	5,707,851,688	6,939,628,049	7,706,707,657	29,440,959,634
Cumulative Variance	4,571,777,881	9,086,772,241	14,794,623,929	21,734,251,978	29,440,959,634	
Variance by Waiver Group						
TANF/SOBRA	3,435,491,250	3,571,292,908	4,116,571,613	4,964,031,982	5,388,327,094	21,475,714,848
SSI	383,160,330	443,953,488	521,551,857	564,059,554	683,350,508	2,596,075,737
AC	-	-	-	-	-	-
ALTCS-EPD	563,552,760	558,303,434	657,913,058	738,572,094	806,473,836	3,324,815,182
ALTCS-DD	510,469,066	598,491,105	707,604,775	805,466,508	932,915,184	3,554,946,638
Family Planning Extension	-	-	-	-	-	-
Expansion State Adults	-	-	-	-	-	-
DSH	(1,392,688)	(1,519,764)	(1,649,933)	6,602	-	(4,555,782)
AI/AN Uncompensated Car	(22,866,717)	(97,192,513)	(53,888,765)	(13,437,080)	(5,038,840)	(192,423,915)
SNCP/DSHP	(296,636,120)	(558,334,298)	(240,250,917)	(119,071,612)	(99,320,126)	(1,313,613,073)
	4,571,777,881	4,514,994,360	5,707,851,688	6,939,628,049	7,706,707,657	29,440,959,634

**Arizona Health Care Cost Containment System
Budget Neutrality Status by Federal Fiscal Year
Total Funds - All Populations
For the Period October 1, 2016 - September 30, 2021
Updated 9-7-16**

	Estimate 2017 DY 6	Estimate 2018 DY 7	Estimate 2019 DY 8	Estimate 2020 DY 9	Estimate 2021 DY 10	Total
Without Waiver						
Expenditure Limit Calculation						
Member Months						
TANF/SOBRA	13,448,230	13,757,771	14,075,365	14,401,332	14,735,971	70,418,669
SSI	2,227,982	2,284,797	2,341,669	2,398,602	2,455,600	11,708,650
ALTCS-EPD	363,227	367,328	371,430	375,531	379,633	1,857,149
ALTCS-DD	362,514	377,076	391,637	406,199	420,761	1,958,186
Expansion State Adults	3,810,951	3,899,900	3,990,187	4,081,836	4,174,877	19,957,751
Combined	20,212,904	20,686,872	21,170,287	21,663,500	22,166,842	105,900,405
Without Waiver PMPM						
TANF/SOBRA	749.11	782.82	818.05	854.86	893.33	821.28
SSI	1,162.52	1,209.02	1,257.38	1,307.68	1,359.99	1,261.72
ALTCS-EPD	6,016.98	6,239.61	6,470.48	6,709.89	6,958.16	6,484.22
ALTCS-DD	6,462.96	6,721.48	6,990.34	7,269.95	7,560.75	7,021.50
Expansion State Adults	719.12	728.45	755.88	775.75	796.29	756.02
Weighted	986.17	1,024.79	1,068.28	1,111.87	1,157.17	1,071.64
Without Waiver Expenditure Limit						
TANF/SOBRA	10,074,203,794	10,769,858,328	11,514,352,024	12,311,122,550	13,164,085,141	57,833,621,837
SSI	2,590,073,439	2,762,365,191	2,944,367,596	3,136,603,670	3,339,592,116	14,773,002,012
ALTCS-EPD	2,185,529,411	2,291,985,660	2,403,328,670	2,519,772,489	2,641,543,676	12,042,159,907
ALTCS-DD	2,342,912,052	2,534,505,562	2,737,677,602	2,953,046,421	3,181,266,770	13,749,408,407
Expansion State Adults	2,740,548,519	2,840,899,689	3,016,091,797	3,166,498,610	3,324,425,764	15,088,464,380
Total	19,933,267,215	21,199,614,429	22,615,817,690	24,087,043,741	25,650,913,468	113,486,656,543
DSH Allotment	161,304,900	134,094,600	120,825,800	107,557,000	94,288,200	618,070,500
Total Without Waiver Expenditure Limit	20,094,572,115	21,333,709,029	22,736,643,490	24,194,600,741	25,745,201,668	114,104,727,043
With Waiver Expenditures						
TANF/SOBRA	4,501,846,917	4,613,275,361	4,904,903,860	5,149,582,662	5,406,495,404	24,576,104,205
SSI	1,779,663,390	1,843,573,143	1,953,812,845	2,051,335,155	2,153,733,581	9,782,118,115
ALTCS-EPD	1,350,003,200	1,391,444,506	1,461,016,732	1,534,067,568	1,610,770,947	7,347,302,953
ALTCS-DD	1,301,738,076	1,363,847,512	1,432,039,888	1,503,641,882	1,578,823,976	7,180,091,335
Expansion State Adults	2,740,548,519	2,840,899,689	3,016,091,797	3,166,498,610	3,324,425,764	15,088,464,380
ALTCS Adult Dental	15,196,200	15,196,200	15,196,200	15,196,200	15,196,200	75,981,000
AI/AN Uncompensated Care	4,000,000	4,000,000	4,000,000	4,000,000	4,000,000	20,000,000
SNCP/DSHP	90,000,000	-	-	-	-	90,000,000
Eliminate Prior Quarter	-	-	-	-	-	-
Expenditure Subtotal	11,782,996,302	12,072,236,412	12,787,061,323	13,424,322,079	14,093,445,873	64,160,061,987
DSH	161,304,900	134,094,600	120,825,800	107,557,000	94,288,200	618,070,500
Total With Waiver Expenditures	11,944,301,202	12,206,331,012	12,907,887,123	13,531,879,079	14,187,734,073	64,778,132,487
With Waiver Expenditure PMPMs						
TANF/SOBRA	334.75	335.32	348.47	357.58	366.89	
SSI	798.78	806.89	834.37	855.22	877.07	
ALTCS-EPD	3,716.69	3,788.01	3,933.49	4,085.06	4,242.97	
ALTCS-DD	3,590.87	3,616.91	3,656.55	3,701.74	3,752.31	
Expansion State Adults	719.12	728.45	755.88	775.75	796.29	
DY1-DY5 BN Carry-over	29,440,959,634					
DY6-DY10 BN Variance	8,150,270,913	9,127,378,017	9,828,756,367	10,662,721,663	11,557,467,595	
Phase-Down of DY6-DY10 Variance	2,037,567,728	2,281,844,504	2,457,189,092	2,665,680,416	2,889,366,899	
Cumulative DY-DY10 Variance	31,478,527,363	33,760,371,867	36,217,560,959	38,883,241,374	41,772,608,273	41,772,608,273
Variance by Waiver Group						
TANF/SOBRA	5,572,356,876	6,156,582,968	6,609,448,163	7,161,539,888	7,757,589,737	33,257,517,632
SSI	810,410,049	918,792,047	990,554,750	1,085,268,514	1,185,858,535	4,990,883,897
ALTCS-EPD	835,526,211	900,541,153	942,311,939	985,704,921	1,030,772,730	4,694,856,955
ALTCS-DD	1,041,173,976	1,170,658,049	1,305,637,714	1,449,404,539	1,602,442,793	6,569,317,072
Expansion State Adults	-	-	-	-	-	-
ALTCS Adult Dental	(15,196,200)	(15,196,200)	(15,196,200)	(15,196,200)	(15,196,200)	(75,981,000)
AI/AN Uncompensated Care	(4,000,000)	(4,000,000)	(4,000,000)	(4,000,000)	(4,000,000)	(20,000,000)
SNCP/DSHP	(90,000,000)	-	-	-	-	(90,000,000)
Eliminate Prior Quarter	-	-	-	-	-	-
	8,150,270,913	9,127,378,017	9,828,756,367	10,662,721,663	11,557,467,595	49,326,594,555

Arizona Health Care Cost Containment System
Budget Neutrality Status by Federal Fiscal Year
Total Funds - All Populations
For the Period October 1, 2016 - September 30, 2021
Updated 1/9/18

	Estimate 2017 DY 6	Estimate 2018 DY 7	Estimate 2019 DY 8	Estimate 2020 DY 9	Estimate 2021 DY 10	Total
Without Waiver						
Expenditure Limit Calculation						
Member Months						
TANF/SOBRA	13,448,230	13,757,771	14,075,365	14,401,332	14,735,971	70,418,669
SSI	2,227,982	2,284,797	2,341,669	2,398,602	2,455,600	11,708,650
ALTCS-EPD	363,227	367,328	371,430	375,531	379,633	1,857,149
ALTCS-DD	362,514	377,076	391,637	406,199	420,761	1,958,186
Expansion State Adults	3,810,951	3,899,900	3,990,187	4,081,836	4,174,877	19,957,751
Combined	20,212,904	20,686,872	21,170,287	21,663,500	22,166,842	105,900,405
Without Waiver PMPM						
TANF/SOBRA	749.11	782.82	818.05	854.86	893.33	821.28
SSI	1,162.52	1,209.02	1,257.38	1,307.68	1,359.99	1,261.72
ALTCS-EPD	6,016.98	6,239.61	6,470.48	6,709.89	6,958.16	6,484.22
ALTCS-DD	6,462.96	6,721.48	6,990.34	7,269.95	7,560.75	7,021.50
Expansion State Adults	719.12	728.45	755.88	775.75	796.29	756.02
Weighted	986.17	1,024.79	1,068.28	1,111.87	1,157.17	1,071.64
Without Waiver Expenditure Limit						
TANF/SOBRA	10,074,203,794	10,769,858,328	11,514,352,024	12,311,122,550	13,164,085,141	57,833,621,837
SSI	2,590,073,439	2,762,365,191	2,944,367,596	3,136,603,670	3,339,592,116	14,773,002,012
ALTCS-EPD	2,185,529,411	2,291,985,660	2,403,328,670	2,519,772,489	2,641,543,676	12,042,159,907
ALTCS-DD	2,342,912,052	2,534,505,562	2,737,677,602	2,953,046,421	3,181,266,770	13,749,408,407
Expansion State Adults	2,740,548,519	2,840,899,689	3,016,091,797	3,166,498,610	3,324,425,764	15,088,464,380
Total	19,933,267,215	21,199,614,429	22,615,817,690	24,087,043,741	25,650,913,468	113,486,656,543
DSH Allotment	161,304,900	134,094,600	120,825,800	107,557,000	94,288,200	618,070,500
Total Without Waiver Expenditure Limit	20,094,572,115	21,333,709,029	22,736,643,490	24,194,600,741	25,745,201,668	114,104,727,043
With Waiver Expenditures						
TANF/SOBRA	4,501,846,917	4,613,275,361	4,904,903,860	5,149,582,662	5,406,495,404	24,576,104,205
SSI	1,779,663,390	1,843,573,143	1,953,812,845	2,051,335,155	2,153,733,581	9,782,118,115
ALTCS-EPD	1,350,003,200	1,391,444,506	1,461,016,732	1,534,067,568	1,610,770,947	7,347,302,953
ALTCS-DD	1,301,738,076	1,363,847,512	1,432,039,888	1,503,641,882	1,578,823,976	7,180,091,335
Expansion State Adults	2,740,548,519	2,840,899,689	3,016,091,797	3,166,498,610	3,324,425,764	15,088,464,380
ALTCS Adult Dental	15,196,200	15,196,200	15,196,200	15,196,200	15,196,200	75,981,000
AI/AN Uncompensated Care	4,000,000	4,000,000	4,000,000	4,000,000	4,000,000	20,000,000
SNCP/DSHP	90,000,000	-	-	-	-	90,000,000
Eliminate Prior Quarter	-	(7,715,000)	(30,860,100)	(32,400,400)	(34,017,700)	(104,993,200)
Expenditure Subtotal	11,782,996,302	12,064,521,412	12,756,201,223	13,391,921,679	14,059,428,173	64,055,068,787
DSH	161,304,900	134,094,600	120,825,800	107,557,000	94,288,200	618,070,500
Total With Waiver Expenditures	11,944,301,202	12,198,616,012	12,877,027,023	13,499,478,679	14,153,716,373	64,673,139,287
With Waiver Expenditure PMPMs						
TANF/SOBRA	334.75	335.32	348.47	357.58	366.89	
SSI	798.78	806.89	834.37	855.22	877.07	
ALTCS-EPD	3,716.69	3,788.01	3,933.49	4,085.06	4,242.97	
ALTCS-DD	3,590.87	3,616.91	3,656.55	3,701.74	3,752.31	
Expansion State Adults	719.12	728.45	755.88	775.75	796.29	
DY1-DY5 BN Carry-over	29,440,959,634					
DY6-DY10 BN Variance	8,150,270,913	9,135,093,017	9,859,616,467	10,695,122,063	11,591,485,295	
Phase-Down of DY6-DY10 Variance	2,037,567,728	2,283,773,254	2,464,904,117	2,673,780,516	2,897,871,324	
Cumulative DY-DY10 Variance	31,478,527,363	33,762,300,617	36,227,204,734	38,900,985,249	41,798,856,573	41,798,856,573
Variance by Waiver Group						
TANF/SOBRA	5,572,356,876	6,156,582,968	6,609,448,163	7,161,539,888	7,757,589,737	33,257,517,632
SSI	810,410,049	918,792,047	990,554,750	1,085,268,514	1,185,858,535	4,990,883,897
ALTCS-EPD	835,526,211	900,541,153	942,311,939	985,704,921	1,030,772,730	4,694,856,955
ALTCS-DD	1,041,173,976	1,170,658,049	1,305,637,714	1,449,404,539	1,602,442,793	6,569,317,072
Expansion State Adults	-	-	-	-	-	-
ALTCS Adult Dental	(15,196,200)	(15,196,200)	(15,196,200)	(15,196,200)	(15,196,200)	(75,981,000)
AI/AN Uncompensated Care	(4,000,000)	(4,000,000)	(4,000,000)	(4,000,000)	(4,000,000)	(20,000,000)
SNCP/DSHP	(90,000,000)	-	-	-	-	(90,000,000)
Eliminate Prior Quarter	-	7,715,000	30,860,100	32,400,400	34,017,700	104,993,200
	8,150,270,913	9,135,093,017	9,859,616,467	10,695,122,063	11,591,485,295	49,431,587,755

Arizona Health Care Cost Containment System
Budget Neutrality Status by Federal Fiscal Year
Total Funds - All Populations
For the Period October 1, 2016 - September 30, 2021
Updated 1/9/18

	Estimate 2017 DY 6	Estimate 2018 DY 7	Estimate 2019 DY 8	Estimate 2020 DY 9	Estimate 2021 DY 10	Total
Without Waiver						
Expenditure Limit Calculation						
Member Months						
TANF/SOBRA	-	-	-	-	-	-
SSI	-	-	-	-	-	-
ALTCS-EPD	-	-	-	-	-	-
ALTCS-DD	-	-	-	-	-	-
Expansion State Adults	-	-	-	-	-	-
Combined	-	-	-	-	-	-
Without Waiver PMPM						
TANF/SOBRA	-	-	-	-	-	-
SSI	-	-	-	-	-	-
ALTCS-EPD	-	-	-	-	-	-
ALTCS-DD	-	-	-	-	-	-
Expansion State Adults	-	-	-	-	-	-
Weighted	-	-	-	-	-	-
Without Waiver Expenditure Limit						
TANF/SOBRA	-	-	-	-	-	-
SSI	-	-	-	-	-	-
ALTCS-EPD	-	-	-	-	-	-
ALTCS-DD	-	-	-	-	-	-
Expansion State Adults	-	-	-	-	-	-
Total	-	-	-	-	-	-
DSH Allotment	-	-	-	-	-	-
Total Without Waiver Expenditure Limit	-	-	-	-	-	-
With Waiver Expenditures						
TANF/SOBRA	-	-	-	-	-	-
SSI	-	-	-	-	-	-
ALTCS-EPD	-	-	-	-	-	-
ALTCS-DD	-	-	-	-	-	-
Expansion State Adults	-	-	-	-	-	-
ALTCS Adult Dental	-	-	-	-	-	-
AI/AN Uncompensated Care	-	-	-	-	-	-
SNCP/DSHP	-	-	-	-	-	-
Eliminate Prior Quarter	-	(7,715,000)	(30,860,100)	(32,400,400)	(34,017,700)	(104,993,200)
Expenditure Subtotal	-	(7,715,000)	(30,860,100)	(32,400,400)	(34,017,700)	(104,993,200)
DSH	-	-	-	-	-	-
Total With Waiver Expenditures	-	(7,715,000)	(30,860,100)	(32,400,400)	(34,017,700)	(104,993,200)
With Waiver Expenditure PMPMs						
TANF/SOBRA	-	-	-	-	-	-
SSI	-	-	-	-	-	-
ALTCS-EPD	-	-	-	-	-	-
ALTCS-DD	-	-	-	-	-	-
Expansion State Adults	-	-	-	-	-	-
DY1-DY5 BN Carry-over						
DY6-DY10 BN Variance	-	7,715,000	30,860,100	32,400,400	34,017,700	
Phase-Down of DY6-DY10 Variance	-	1,928,750	7,715,025	8,100,100	8,504,425	
Cumulative DY-DY10 Variance	-	1,928,750	9,643,775	17,743,875	26,248,300	26,248,300
Variance by Waiver Group						
TANF/SOBRA	-	-	-	-	-	-
SSI	-	-	-	-	-	-
ALTCS-EPD	-	-	-	-	-	-
ALTCS-DD	-	-	-	-	-	-
Expansion State Adults	-	-	-	-	-	-
ALTCS Adult Dental	-	-	-	-	-	-
AI/AN Uncompensated Care	-	-	-	-	-	-
SNCP/DSHP	-	-	-	-	-	-
Eliminate Prior Quarter	-	7,715,000	30,860,100	32,400,400	34,017,700	104,993,200
	-	7,715,000	30,860,100	32,400,400	34,017,700	104,993,200

Arizona Health Care Cost Containment System
Budget Neutrality Status by Federal Fiscal Year
NEWLY ELIGIBLE ADULTS
For the Period January 1, 2014 - September 30, 2016

Without Waiver	Estimate	Estimate	Estimate	
Expenditure Limit Calculation	2014	2015	2016	
Member Months	DY 3	DY 4	DY 5	Total
Newly Eligible Adults	248,598	871,458	1,235,338	2,355,394
Without Waiver PMPM				
Newly Eligible Adults	578.54	605.73	634.20	617.79
Without Waiver Expenditure Limit				
Newly Eligible Adults	143,823,900	527,869,500	783,452,200	1,455,145,600
With Waiver Expenditures				
Newly Eligible Adults	96,168,214	299,658,919	486,640,974	882,468,107
With Waiver Expenditure PMPMs				
Newly Eligible Adults	386.84	343.86	393.93	
Budget Neutrality Variance	47,655,686	228,210,581	296,811,226	572,677,493
Cumulative Variance	47,655,686	275,866,267	572,677,493	

**Arizona Health Care Cost Containment System
Budget Neutrality Status by Federal Fiscal Year
NEWLY ELIGIBLE ADULTS
For the Period October 1, 2016 - September 30, 2021**

	Estimate 2017 DY 6	Estimate 2018 DY 7	Estimate 2019 DY 8	Estimate 2020 DY 9	Estimate 2021 DY 10	Total
Without Waiver						
Expenditure Limit Calculation						
Member Months						
Newly Eligible Adults	1,090,784	1,162,971	1,235,157	1,307,344	1,379,531	6,175,787
Without Waiver PMPM						
Newly Eligible Adults	655.13	676.75	699.08	722.15	745.98	702.47
Without Waiver Expenditure Limit						
Newly Eligible Adults	714,605,361	787,040,412	863,473,775	944,098,426	1,029,102,212	4,338,320,187
With Waiver Expenditures						
Newly Eligible Adults	461,279,900	496,165,279	538,104,400	591,914,839	651,106,323	2,738,570,742
Eliminate Prior Quarter	-	-	-	-	-	-
	461,279,900	496,165,279	538,104,400	591,914,839	651,106,323	2,738,570,742
With Waiver Expenditure PMPMs						
Newly Eligible Adults	422.89	426.64	435.66	452.76	471.98	
DY1-DY5 BN Carry-over	572,677,493					
DY6-DY10 BN Variance	253,325,461	290,875,133	325,369,375	352,183,587	377,995,889	
Phase-Down of DY6-DY10 Variance	63,331,365	72,718,783	81,342,344	88,045,897	94,498,972	
Cumulative DY-DY10 Variance	636,008,858	708,727,642	790,069,985	878,115,882	972,614,854	972,614,854
Variance by Waiver Group						
Eliminate Prior Quarter	-	-	-	-	-	-

**Arizona Health Care Cost Containment System
Budget Neutrality Status by Federal Fiscal Year
NEWLY ELIGIBLE ADULTS
For the Period October 1, 2016 - September 30, 2021**

	Estimate 2017 DY 6	Estimate 2018 DY 7	Estimate 2019 DY 8	Estimate 2020 DY 9	Estimate 2021 DY 10	Total
Without Waiver						
Expenditure Limit Calculation						
Member Months						
Newly Eligible Adults	1,090,784	1,162,971	1,235,157	1,307,344	1,379,531	6,175,787
Without Waiver PMPM						
Newly Eligible Adults	655.13	676.75	699.08	722.15	745.98	702.47
Without Waiver Expenditure Limit						
Newly Eligible Adults	714,605,361	787,040,412	863,473,775	944,098,426	1,029,102,212	4,338,320,187
With Waiver Expenditures						
Newly Eligible Adults	461,279,900	496,165,279	538,104,400	591,914,839	651,106,323	2,738,570,742
Eliminate Prior Quarter	-	(2,142,750)	(8,571,000)	(9,428,100)	(10,370,910)	(30,512,760)
	461,279,900	494,022,529	529,533,400	582,486,739	640,735,413	2,708,057,982
With Waiver Expenditure PMPMs						
Newly Eligible Adults	422.89	426.64	435.66	452.76	471.98	
DY1-DY5 BN Carry-over						572,677,493
DY6-DY10 BN Variance	253,325,461	290,875,133	325,369,375	352,183,587	377,995,889	
Phase-Down of DY6-DY10 Variance	63,331,365	72,718,783	81,342,344	88,045,897	94,498,972	
Cumulative DY-DY10 Variance	636,008,858	708,727,642	790,069,985	878,115,882	972,614,854	972,614,854
Variance by Waiver Group						
Eliminate Prior Quarter	-	2,142,750	8,571,000	9,428,100	10,370,910	30,512,760
	-	2,142,750	8,571,000	9,428,100	10,370,910	30,512,760

Arizona Health Care Cost Containment System
Budget Neutrality Status by Federal Fiscal Year
NEWLY ELIGIBLE ADULTS
For the Period October 1, 2016 - September 30, 2021

	Estimate 2017 DY 6	Estimate 2018 DY 7	Estimate 2019 DY 8	Estimate 2020 DY 9	Estimate 2021 DY 10	Total
Without Waiver						
Expenditure Limit Calculation						
Member Months						
Newly Eligible Adults	-	-	-	-	-	-
Without Waiver PMPM						
Newly Eligible Adults	-	-	-	-	-	-
Without Waiver Expenditure Limit						
Newly Eligible Adults	-	-	-	-	-	-
With Waiver Expenditures						
Newly Eligible Adults	-	-	-	-	-	-
Eliminate Prior Quarter	-	(2,142,750)	(8,571,000)	(9,428,100)	(10,370,910)	(30,512,760)
	-	(2,142,750)	(8,571,000)	(9,428,100)	(10,370,910)	(30,512,760)
With Waiver Expenditure PMPMs						
Newly Eligible Adults	-	-	-	-	-	-
DY1-DY5 BN Carry-over	-	-	-	-	-	-
DY6-DY10 BN Variance	-	-	-	-	-	-
Phase-Down of DY6-DY10 Variance	-	-	-	-	-	-
Cumulative DY-DY10 Variance	-	-	-	-	-	-
Variance by Waiver Group						
Eliminate Prior Quarter	-	2,142,750	8,571,000	9,428,100	10,370,910	30,512,760
	-	2,142,750	8,571,000	9,428,100	10,370,910	30,512,760

APPENDIX 2: TRIBAL CONSULTATION





AHCCCS TRIBAL CONSULTATION MEETING

With Tribal Leaders, Tribal Members, Indian Health Services, Tribal Health Programs Operated Under P.L. 93-638 and Urban Indian Health Programs

Date: January 11, 2018
Time: 9:00 a.m. – 12:00 p.m. (Phoenix Time)
Location: AHCCCS Administrative Offices, 3rd Floor Gold and Salmon Conference Rooms, 701 E. Jefferson St., Phoenix, AZ 85034
Conference Call-In: 1-877-820-7831, Participant Passcode: 108903#

AGENDA

TIME	TOPIC	Presenter
9:00 - 9:15 a.m.	Welcome.....	Jami Snyder, <i>AHCCCS Deputy Director</i>
	Invocation.....	Theresa Galvan, <i>Health Services Administrator Navajo Nation Department of Behavioral Health Services</i>
	Introductions.....	Deputy Director Snyder
9:15 – 10:15 a.m.	AHCCCS Update: <ul style="list-style-type: none"> • Waiver Update • Budget Update • Flexibilities Update 	Deputy Director Snyder
10:15 - 10:40 a.m.	Quality Strategy	Jakenna Lebsock, <i>Clinical Administrator DHCM, Clinical Quality Management</i>
10:40- 11:00 a.m.	Electronic Visit Verification (EVV) Update	Dara Johnson, <i>Program Development Officer Division of Health Care Management</i>
11:00 - 11:20 a.m.	638 Federally Qualified Health Centers (FQHC)	Markay Adams, <i>Assistant Director Division of Fee for Service Management</i>
11:20 - 11:40 a.m.	State Plan Amendment (SPA) Update <ul style="list-style-type: none"> • DRG Rebase • Personal Needs Allowance • IHS/638 Specialty Drug Reimbursement • 638 FQHC 	Kyle Sawyer, <i>Intergovernmental Relations Specialist Office of Intergovernmental Relations</i>
11:40 - 11:55 a.m.	Waiver Update <ul style="list-style-type: none"> • Prior Quarter Coverage-Proposed Change 	Liz Lorenz, <i>Assistant Director Office of Intergovernmental Relations</i> Mohamed Arif, <i>Waiver Manager Office of Intergovernmental Relations</i>
11:55-12:00 p.m.	Announcements/Wrap-Up/Adjourn	Deputy Director Snyder



TRIBAL CONSULTATION MEETING

Summary

January 11, 2018

9:00 a.m. –12:00 a.m. (Arizona Time)

Conference Bridge: 1-877-820-7831, Participant Passcode: 108903#

NOTIFICATION TO TRIBES:



Tribal Relations

AHCCCS Tribal Consultation Meeting Announcement January 11, 2018

Greetings,

I'm pleased to announce the first quarterly AHCCCS Tribal Consultation meeting of 2018. The meeting is scheduled for **January 11, 2018** at the AHCCCS Administrative Offices, 3rd Floor Gold and Salmon Conference rooms, 701 E. Jefferson St., Phoenix, AZ 85034 from 9:00 a.m. – 12:00 p.m. (Arizona time). If you intend to participate by conference call, please dial **1-877-820-7831** and enter participant code, **108903#**.

Just a reminder to mute your phones but do not place your phones on hold as this will disrupt the meeting with music.

[Click this link to see the draft meeting agenda](#) and [this link to see the draft 2018 quarterly tribal consultation meeting schedule](#).

Please inform me if leaders from your tribe will attend this meeting as it is AHCCCS Director Betlach's practice to recognize tribal dignitaries. Meeting materials will be posted to the AHCCCS website a couple of days prior to the meeting. Thank you in advance for your participation in this important meeting.

Wishing you all the best in 2018!

Bonnie Talakte
Tribal Relations Liaison
Office of Intergovernmental Relations
MD-4100 | 801 E. Jefferson, Phoenix, AZ 85034
(602) 417-4610 (Office) | (602) 918-7798 (Cell)
Bonnie.Talakte@azahcccs.gov



AHCCCS TRIBAL CONSULTATION MEETING

With Tribal Leaders, Tribal Members, Indian Health Services, Tribal Health Programs Operated Under P.L. 93-638 and Urban Indian Health Programs

Date: January 11, 2018

Time: 9:00 a.m. -12:00 p.m. (Phoenix Time)

Location: AHCCCS Administrative Offices, 3rd Floor Gold and Salmon Conference Rooms, 701 E. Jefferson St., Phoenix, AZ 85034

Conference Call-In: **1-877-820-7831**, Participant Passcode: **108903#**

AGENDA

TIME	TOPIC	PRESENTER
9:00 – 9:15 a.m.	Welcome.....	Jami Snyder, <i>AHCCCS Deputy Director</i>
	Invocation.....	Theresa Galvan, <i>Health Services Administrator Navajo Nation Department of Behavioral Health Services</i>
	Introductions.....	Deputy Director Snyder
9:15-10:15 a.m.	AHCCCS Update: <ul style="list-style-type: none"> • Waiver Update • Budget Update • Flexibilities Update 	Deputy Director Snyder
10:15-10:40 a.m.	Quality Strategy	Jakenna Lebsock, <i>Clinical Administrator DHCM, Clinical Quality Management</i>
10:40-11:00 a.m.	Electronic Visit Verification (EVV) Update	Dara Johnson <i>Program Development Officer Division of Health Care Management</i>
11:00-11:20 a.m.	638 Federally Qualified Health Centers (FQHC)	Markay Adams, <i>Assistant Director Division of Fee for Service Management</i>
11:20-11:40 a.m.	State Plan Amendment (SPA) Update <ul style="list-style-type: none"> • DRG Rebase • Personal Needs Allowance • IHS/638 Specialty Drug Reimbursement • 638 FQHC 	Kyle Sawyer, <i>Intergovernmental Relations Specialist Office of Intergovernmental Relations</i>
11:40-11:55 a.m.	Waiver Update <ul style="list-style-type: none"> • Prior Quarter Coverage Proposal Change 	Liz Lorenz, <i>Assistant Director Office of Intergovernmental Relations</i>
11:55-12:00 p.m.	Announcements/Wrap-Up/Adjourn	Deputy Director Snyder

ATTENDEES:

Tribes	<u>Navajo Nation:</u> Gen Holona, Marie Keyonnie, Theresa Galvan, <u>Pascua Yaqui Tribe:</u> Reuben Howard, Rosa Rivera <u>San Carlos Apache Tribe:</u> Vickie Began, Ron Ritter, Natsai Zhou <u>Tohono O’odham Nation:</u> Chester Antone, Kenneth Tiller, Joe Clifton <u>White Mountain Apache Tribe:</u> Ryan Johnson, Vangie Natann, Jessica Rudolpho, Bethani Thomas, Kevin McKenzie, Felix Benally; Lona Hinton, Ginger Myers, Diane Johnson
I/T/Us	<u>Navajo Area IHS:</u> Marie Begay <u>Phoenix Area IHS:</u> Arikah McClary
Other	<u>Arizona Advisory Council on Indian Health Care:</u> Kim Russell <u>Care 1st Health Plan:</u> Jearlyn Tsoisie, Scott Cummings <u>Cenpatico:</u> Sheina Yellowhair <u>Center for Medicare & Medicaid (CMS):</u> Lane Terwilliger <u>Ft. Defiance Indian Health Care Corporation:</u> <u>Inter Tribal Council of Arizona (ITCA):</u> Verna Johnson <u>Native Health:</u> Deanna Sangster <u>Native Resource Development:</u> Jermiah Kanuho <u>Social Security :</u> Kimberly Yellow Robe <u>Tuba City Regional Health Care Corporation:</u> Lynette Bonar
On Phone	Melissa Humetewa, Catherine Anderson, Christine MCGinty, Yvonne Damon, Jim Smith, Christine Becenti, Terri Chee, Sandy Aretino, Alutha Yellowhair, Alicia Shields, Julia Chavez, Sandy Borys, Dan Marino, Alida Montiel, Joni Jim, Jason Boraga, Yvonne-Kee-Billison, Cecelia Jackson, Carol Chitwood, Paddock
AHCCCS Representatives	Jami Snyder, Elizabeth Carpio, Elizabeth Lorenz, Jakenna Lebsack, Dara Johnson, Markay Adams, Valerie Jones, Matt Devlin, Toni Tapia, Lisa DeWitt, Sandi Borys, Heidi Capriotti, Bonnie Talakte, Kyle Sawyer, Leslie Short, Carol Parra

All meeting materials and presentations can be found at the AHCCCS Tribal Consultation website <https://www.azahcccs.gov/AmericanIndians/TribalConsultation/meetings.html>

MEETING SUMMARY

AHCCCS UPDATES – Presenter: Jami Snyder, Deputy Director
<p><u>American Indian Health Program (AIHP) Population:</u></p> <ul style="list-style-type: none"> Starting in 2011, the enrollment freeze impacted the AIHP population. There was a steady decline from a high of 100,000 to a low of 80,000 in 2013. When the State expanded health care, the AIHP population recovered to approximately 115,000 in 2017. <p><u>Integration Journey:</u></p> <ul style="list-style-type: none"> Over the past several years AHCCCS has focused on “whole person” health and the integration of behavioral health and physical health services for AHCCCS members. ALTCS RFP was released on 10/16 and awarded on 3/17 and is now a fully integrated service product AHCCCS Complete Care RFP was released on 10/17. Award contract on 3/18 with transition to take place on 10/1/18 <p><u>Complete Care Timeline:</u> 1.5M of the 1.9M AHCCCS enrollees will be engaged at some level in the transition as a result of this contract.</p>

Activity	Target Date
Issue Request for Proposal (RFP)	November 1, 2017
Proposals Due	January 25, 2018
Contracts Awarded	By March 8, 2018
Transition Activities Begin	March 9, 2018
Contract Start	October 1, 2018

- Important Facts: American Indian (AI) members will continue to have choice and will be able to switch enrollment between integrated Fee For Service (FFS) or an Integrated Contractor at anytime
- Choice options remain for AI members with SMI
- AI members enrolled in AIHP/FFS can seek services from any AHCCCS registered provider at anytime if the provider accepts FFS; services are **not limited** to IHS/638 providers for AIHP enrolled members
- AI members enrolled in a managed care plan **can** access services from an IHS/638 facility at anytime; services are **not limited** to providers outside of IHS/638 facilities

Questions/Comments:

Q: *What is the impact to tribal foster children?*

A: *There is no impact on tribal foster children. Tribal foster children are not enrolled in the Comprehensive Medical & Dental Program (CMDP) so there is no impact.*



Q: *What kind of analysis was done in terms of the impact to Natives as well as tribal programs in this effort? And what is the reimbursement rate going to be and how are you encouraging the RBHA's to contract with tribes?*

A: *If a member goes to an IHS or tribal 638 to receive care, that claim is not adjudicated through the plan. It comes directly to AHCCCS and we look at maintaining that process going forward. Depending on the service, it would be reimbursed at the AIR or fee schedule as it is today.*



Q 1: *In regard to the contracts, can you speak to specific contract requirements for Native Americans?*

Q 2: *How is dental health being integrated into the "whole health" piece?*

A 1: *The solicitation is posted online. Since we have restricted disclosure requirements, we are limited to what we can say about the RFP. However, what we did require of all the health plans is to have a tribal liaison in their staffing structures to interact with tribal communities within their Geographic Service Areas (GSAs). There is a requirement around engagement and outreach for Title XIX (19) members. For Title XIX (19) members there is a prohibition to engage in direct billing relationships because the claims are sent directly to AHCCCS. That's different for KidsCare under Title XXI (21). There are expectations around Care Coordination for members they serve. The more specific language is posted on-line related to those requirements.*

A 2: *Arizona is ahead of the game relative to other states in that our MCO's subcontract directly with dental maintenance organizations. The sharing of information data around enrollees is much more fluid and direct opportunity within our system within the MCO system. We continue to discuss this topic internally.*



Q1: *When a Native person goes to an assigned RBHA how will that work in regard to assigning them to an MCO program? When you say they are going to be integrated and responsible for providing health care how will that work?*

A1: *It's integration from a payer perspective. The model already exists within the RBHA construct. For those who are seriously mentally ill and are assigned to an integrated RBHA plan, that plan is responsible for that individual's behavioral health services and the coordination and payment of those services but also for their physical health services. That plan is responsible for broadening their network beyond behavioral health providers to include physical health providers to serve individuals. The next step of integration is building upon that. It's now taking the physical health plan that has traditionally been responsible for acute care and now being responsible for behavioral health care. As of 10/1/18, if an American Indian AHCCCS member chooses AIHP for the integrated FFS, it will either be AIHP, who's responsible for physical & behavioral health, or an AIHP for physical health and a TRBHA they select.*

Q2: *How's that going to work with auto enrollment?*

A2: *That is one of the things they are trying to work out before we operationalize. Making sure to preserve membership as it's appropriate.*

A2: *For individuals with a lived experience of serious mental illness, their choice options will remain the same. In other words, they can choose to receive their physical health and behavioral health through an integrated RBHA or to receive their physical health through AIHP or behavioral health through a TRBHA. American Indians will continue to have choice.*



C: *There is still going to be a need to have a relationship between the AHCCCS Complete Care (ACC) plan and TRBHAs going forward so that there is coordination of care and the individual will know they can still be able to get their services at the TRBHAs. I don't know if the ACC plan is seeking to have a relationship with the TRBHAs. That's something that should be considered going forward.*

R: *That is an excellent and critical comment. As we look to operationalize this product line those considerations are going to be critical.*



Q: *You mentioned utilization data. Is there going to be time when we are permitted to look at the existing data? Can that data be provided so we can see where there is a plus or minus as far as how the services are supposed to be delivered? So we can look at the trends.*

A: *At one of the future Tribal Consultation meetings, we can show the group the initial assignment numbers and how they fall out. From that point on, we will provide data that shows shifts that are taking place in how individuals are making choices.*



Q: *Will the Acute, MCO and TRBHA will be initially assigned to an ACC plan? There are 3 options right? Will there be an option to be on the ACC plan for physical and TRBHA for behavioral and an option for AIHP for both integrated and an option of AIHP for physical and TRBHA for behavioral?*

A: *It's ACC for the initial assignment or AIHP if there is not a TRBHA available, or AIHP and TRBHA if there is a TRBHA in the individual service area. What is going away as part of Integration is an option for General Mental Health/Substance Abuse (GMH/SA). There is not an MCO/TRBHA option for assignment. An American Indian member will either select an integrated MCO or an integrated AIHP FFS that includes either AIHP total or a TRBHA depending on their current location and if a TRBHA is available.*



C: *When you talk about the relationship that needs to be developed between the ACC plan and the TRBHA, it should be similar to what exists now between the integrated RBHA and TRBHA.*

R: *Yes, that is correct.*

Flexibilities Update: AHCCCS submitted a letter to CMS on 11/17/17. The letter informed CMS that AHCCCS will be pursuing a number of flexibilities that may be available. These flexibilities will curb regulations. There is a process around officially requesting flexibilities for each of the components that includes a public comment period. The following flexibilities were requested:

- NEMT limits in urban area for those over 100% of federal poverty level
- Eliminate prior-quarter coverage; return to what was in place prior to 1/1/2014
- More leverage on prescription drugs
- Modernize and stabilize Federally Qualified Health Centers (FQHC) payments
- Waiver from regulatory burdens of access rule

Questions:

C: *Do you mean limit but not eliminate Non-Emergency Medical Transportation (NEMT) coverage?*

A: *It means eliminate coverage for a very specific population in a specific area of the state. So eliminate the NEMT benefit for able bodied adults in urban areas.*



Q: *In regard to prior quarter coverage, it's a financial issue for IHS/638 facilities. Just give us 100% pass through for reimbursement so we don't have to go through this process again.*

A1: *Your comment is well taken. One point of clarification, you are correct in that its 100% pass through for*

services received through IHS/638 facilities. However, our American Indian members receive services outside of the IHS/638 facilities as well. These are not 100% pass through dollars. It's important for us to continue to keep in mind what it looks like for our IHS/638 facilities and providers which are different from when members access services from an MCO.

A2: Every waiver that we submit is going to be reviewed by CMS. Ultimately it will be approved or denied so CMS will have the final say on any exemption... It's worth considering that some of these points be discussed at the federal level. That may be more efficient.

↻

Q1: In regard to eliminating prior quarter coverage, when there is already a law that allows this to be in place. Does the approval of the flexibility mean that you waive the law?

A1: Federal law requires that we offer prior quarter coverage, coverage back to the 3 months preceding the date of application. We are suggesting with our waiver request that we be relieved of that responsibility and only retroactively offer coverage to the beginning of the month rather than the 3 prior months.

Q1: Would there be some consideration for a patient in the middle of a treatment that could interrupt reimbursement for that particular stream of treatment?

A2: That is the kind of discussion that needs to occur in the context of this meeting and in the public comment period. If that's a consideration, we want you to issue a comment so we can take that into consideration as we finalize the waiver submission.

↻

Q: Are you going to be conducting the public hearings for this process?

A: Yes, we will be conducting public forums.

AHCCCS Works Waiver: Following an extensive public comment period, AHCCCS submitted the waiver_request to CMS to implement AHCCCS Works.

- Proposed requirement of 20 hours per week:
 - Employed
 - Attending school full time
 - Attending an employment support and development activity
- Members subject to requirement who do not qualify for an exemption and fail to meet the requirements will receive an initial 6-month grace period
- Failure to comply after the grace period will result in a termination of AHCCCS enrollment
- Members may re-enroll once they can demonstrate compliance for at least the past 30 days
- Five-year maximum lifetime coverage limit for able bodied adult members who are subject to the above AHCCCS Works requirements and do not fall under one of the identified exemptions
- Expecting CMS to issue guidance to states and take action on other state submittals in near future
- Will begin discussions with CMS
- Evaluating operational changes necessary

Works Exemptions: Focus on able-bodied adults ages 19-55 with the following exemptions:

- American Indians
- Pregnant and post-partum women (through the month in which 90th day post-partum occurs)
- Former Arizona foster youths up to 26
- Individuals receiving long-term disability benefits
- Individuals diagnosed with a SMI
- Full time high school, college or graduate students
- Victims of domestic violence
- Individuals who are homeless
- Parents, caretakers relatives, and foster parents
- Caregivers of a family member who is enrolled in ALTCS
- Individuals who have recently been directly impacted by a catastrophic event such as a natural disaster or the death of a family member living in the same household.

Impact to population: AHCCCS is expecting CMS to issue guidance to states and take action on other state submittals in the near future. We Will begin discussions with CMS and evaluating operational changes necessary

- Approximately 400,000 in eligibility group included in waiver
- 43,719 American Indians - 19-55 category
- 12,912 individuals determined to have SMI
- 81,124 age 55 and over
- 269,507 individuals remaining prior to inclusion of other exempt populations

Questions/Comments:

Q1: *When do you expect the final decision from CMS for all the exemptions?*

A1: *We anticipate they will work chronologically down the list of state submissions. Kentucky is probably the first one. They will have to sift through the different exemptions and requirements. We will initiate conversations which will extend over a period of time.*

Q2: *Are you aware of any states that have exemptions for American Indians?*

A2: *We might be the only one. We'll have to double check.*

~

Q: *What is the public comment period?*

A: *On this request, the public comment has ended but the federal comment period will end on February 5, 2018.*

~

C: *I want to address the other states that choose the work requirements and have exempted AI. It is all over the place. Different proposals that say they're exempting American Indians such as Indiana. Contact your local TTAG representative for more information.*

Budget Update: the Governor's budget will be released tomorrow. It will be a status quo budget but will focus on enhanced funding for K-12.

CHIP/KidsCare Funding Update: The program expired at the end of December 2017 but States have carryover funds to get them through in the absence of re-authorization of the program. What that means for Arizona is that we were offered \$64M for re-distribution funds to continue to maintain the program in the absence of that re-authorization to carry us through the end of the calendar year. In late December, Congress authorized, through a Continuing Resolution (CR) that gave \$36.9M to Arizona. We believe the additional appropriation will carry us through February to March but not through the end of March.

Questions/Comments:

Q: *What are the options?*

A: *We do have a couple of options. 1) Take advantage of the re-distribution funding and continue to work with our federal partners, 2) There is a way for us to shift expenditures to Title XIX (19) to free up some funding. There would be an operational fix. That would be our fall back solution.*

~

Q: *Originally CHIP was established as separate program and not an extension of Medicaid. What is the chance of going back to that?*

A: *States vary in terms of their approach. That hasn't been a consideration in Arizona up to this point. It hasn't been a part of the discussion today but could be a conversation we could have.*

QUALITY STREATEGY – Presenter: Jakenna Lebsock, Clinical Administrator, DHCM

Definition of Quality: Health care quality is defined as services that promote optimized health and meet current standards of care. It can be different for every individual and includes timely access to care, safe and appropriate treatment, and is supportive of individual needs, goals, and preferences. It is member focused with immediate attention to health and safety. It is strength based and is based on continuous improvement. There is open communication and opportunities to learn from each other to find the best solutions.

Desired Feedback Questions:

1. What does quality mean to you?

2. How can AHCCCS support the tribes/tribal members in obtaining or providing quality care and services?

Questions/Comments:

C: *One of the things we are struggling with as a TRBHA is that most of the MCO's do not understand what a TRBHA is. We struggle with the fact that we have to educate every single provider; acute, any service provided off-reservation. We need assistance with the education of services off reservation.*



C: *We are working on the health exchange. It is so important to be able to get patient information back quickly so we can do the follow-up care so the patient doesn't get readmitted. There are lots of reasons for the coordination of care.*



Q: *What kind of reports do you send us with regard to quality and coordination of care?*

A1: *In terms of coordination of care, we tend to leave that to the provider level. We get involved at AHCCCS when there is concern or if we hear that information is not being shared. We push education as an expectation and work to support health plans and TRBHAs to share that information. If we get a call from a member or provider with a concern we share the concerns with the party responsible for the care. We try to be as responsive as possible and provide a timeframe for resolution. If we see any trends about concerns or activity that is happening we will reach out and report what we are seeing from a reporting level. We will supply findings and provide technical assistance.*

A2: *Today, the sharing of information is limited for various reasons, limited resources being one. AIHP is connected to the Health Information Exchange (HIE). DFSM has limited the alerts for Admits, Discharges, and Transfers (ADT's). If you are in HIE, you can get alerts for members every time they are admitted, discharged or transferred. It is based on how timely the hospital enters information into the HIE. Usually it's the same day. In AIHP, we have limited the information to high needs/high costs because we have 1 person getting the alerts. We coordinate with the TRBHA's using that information.*



C: *There also need for training on accessing data and what is the best way to do it. Many of us are working on getting connected to HIE.*

R: *Based on this conversation, is there value in having HIE provide a presentation at the next tribal consultation meeting, about who they are and what they do?*



C: *There is such a great disconnect between hospitals and tribal health facilities. What are the other streams of communication?*

R: *You also have to look internally at who has access to the Secure File Transfer Protocol (SFTP). It is very important to manage internally so you know who has access to that information and can draw down the data. It's the PHI data we transfer to providers.*

Purpose of the Quality Strategy: A coordinated, comprehensive, and proactive approach to drive quality throughout the AHCCCS system. It outlines expectations around meeting/exceeding standards related to access to care and quality of care/services and highlights Agency approaches program/system development and oversight

Federal Regulation Requirements: Topics must include:

- State-defined network adequacy and availability of services
- State goals and objectives for continuous quality improvement
- Cover populations in the State served by MCOs
- Detailed description of quality metrics and performance targets
- Performance Improvement Project processes
- Sanctions/regulatory actions
- External Quality Review processes

Major Areas of Focus – American Indian Specific:

- American Indian fluidity between FFS and Managed Care - member's right to choose delivery system
- Integration and Ease of System Navigation – how care and services can be delivered

- Policy Efforts – inclusive and representative of all populations
- Care-Coordination
- American Indian Medical Home (AIMH) Model – reasons for implementation
- Data/Information Sharing – enhancement of efforts

Questions/Comments

Q: *How is AHCCCS getting true tribal consultation on how to move forward with the effort?*

R: *The Division of Fee for Service Management (DFSM) takes a lead on these efforts. When it comes to anything that goes into policy, it goes to tribal consultation then through 45 days for public comment. There is extensive stakeholder engagement that occurs.*

Collaboration with Tribes or IHS/638 Facilities:

- Tracking and trending to identify potential concerns such as appropriateness of placement setting or improper seclusion/restraints
- Openly share concerns and offer assistance with investigations
Support quality improvement efforts such as meeting with tribal facilities to provide process review and share lessons learned

Quality Strategy Goals/Objectives:

- Set clear expectations for member care
- Improve AHCCCS members' health status
- Partner with sister agencies, MCOs, IHS/Tribal 638 facilities, and other providers to improve access to care
- Build capacity in rural/underserved areas
- Improve member satisfaction/experiences
- Continue to enhance data-driven decision making
- Support/promote innovative and quality care

Agency Initiatives:

- Autism Spectrum Disorder
- Integrated Health Care
- Opioid Crisis
- Care/Services for children in Foster Care system
- Justice population (early reach-in)
- Commitment to ongoing learning
- Workforce Development
- Employment
- Housing

Desired Feedback Questions:

1. Are there other initiatives or activities that we should focus on?
2. Are we missing any major topics that are of concern?
3. What is the best way s to get additional information about these topics?

Questions/Comments:

Q1: *From the data that AHCCCS has, can some of the issues be answered?*

A1: *Are you asking if AHCCCS has the resources in place to address them?*

Q2: *I'm asking if AHCCCS has sufficient data to know what the quality initiatives are. Are they meeting them and how do they resolve them?*

A2: *A part of that is the process that we use. If we feel we don't have the enough data we'll go back and ask more questions, we'll request clinical documentation or schedule a phone call with a TRBHA or the Providers for additional information. There is a lot of internal collaboration that occurs among divisions. We have processes in place to delineate an IHS and 638 facility vs a non-IHS/non-638 facility. We work very hard to not over simplify what we are seeing in the data in terms of tracking and trending.*

Q1: Do you know the data when it comes to AIHP members that are re-admitted to hospitals? I'm looking at this collectively for acute care. What is that percentage of re-admits?

A1: I don't know the percentage at this time but can get that information based on the data we have. We're also looking at incorporating AIHP data into a specific project we're doing on behavioral health re-admissions that is a subset of the overall re-admissions rate. We just started that data project last month so we can definitely share that as we get more information

Q2: Is there someone that AHCCCS has in hospitals that can help with all American Indians? I look at better care that may save dollars.

A2: No, AIHP is a fee for service model. It sounds like you're looking for like a patient navigator. We have limited staff in the health plan. It's not something we have historically done.

Major Strategies:

- Alignment with the Agency Strategic Plan
- Value-Based Purchasing
- Targeted Investments
- Quality Management (Critical Incident investigation)
- Strategic Partnerships
- Network Adequacy
- Stakeholder Engagement

Questions:

- What additional strategies or opportunities should we consider?
- What are the best approaches to implementing these strategies?
- Is there anything that AHCCCS needs to be mindful of as we pursue these opportunities?

Questions/Comments:

C: There is a vast amount of information that comes out of AHCCCS. Asking us as TRBHA's and as tribes to sort through the minutiae, does this apply to AIHP or not, is cumbersome and difficult given the limited recourses we have as well. Having some type of strategy, procedure or process that could streamline communication with TRBHA's and tribal communities are things that are specific to the AIHP that would be relevant for you. There is disconnect in communication and finding a type of strategy would be helpful for us. Please be mindful that we need support from AHCCCS in streamlining assistance in order to provide our clients the best amount of quality services we can. It should be the same if not better than what people get off the reservation.

R: Thank you for your feedback. In terms of care coordination for the TRBHA's, Leslie is the point of contact. Leslie and her team are the conduit and are subject matter experts.

**ELECTRONIC VISIT VERIFICATION – Presenter: Dara Johnson, Program Development Officer, DHCM
Presentation Re-Scheduled to February 1, 2018 Special Teleconference & Webinar**

**638 FEDERALLY QUALIFIED HEALTH CENTERS (FQHC) UPDATE
Presenter: Markay Adams, Assistant Director DFSM**

This is a new provider type that stems from guidance issued by CMS which allows 638 clinics to opt-in to become an FQHC. If you are a Provider type 05 Out-Patient Clinic or 77 Behavioral Health Out Patient Clinic you will have the opportunity to opt-in to this new provider type. This will require a new Provide code which is C5-638 FQHC that will become available April 1, 2018. We are sending targeted communication at the end of January 2018 to 638 clinics that have gone through our Provider Registration to make sure that every clinic is aware of this option.

Questions:

Q: Who will you send the announcement to?

A: It will be sent to 638 out-patient clinics that have gone through provider registration. If we don't have

accurate information we will reach out to our contacts on file. We encourage you to contact the Provider Registration unit to inform them of any contact changes.

STATE PLAN AMENDMENT (SPA) UPDATE

Presenter: Kyle Sawyer, Intergovernmental Relations Specialist, OIR

Nursing Facility Rate Changes: This SPA is a change in nursing facility rates that were increased across the board by .7% as of January 1, 2018. These rates will go into our state plan.

Diagnostic Related Group (DRG) Rebase: As of January 1, 2018, AHCCCS has rebased (new base level) the All Patient Refined (APR)-Diagnostic Related Group (DRG) methodology. This does not impact IHS/638 facilities which are not subject to DRG as they are reimbursed at the All Inclusive Rate (AIR). What is included in the rebase are updates to relative weights, DRG base rates, policy adjusters, adds additional adjusters for Burns and “all other procedures”. The rebase also updates outlier ratios and removes the Documentation and Coding Improvement (DCI) and transition adjustment factors. Additional information can be found at: <https://www.azahcccs.gov/PlansProviders/RatesAndBilling/FFS/APRDRGrates.html>

Personal Needs Allowance: This is for the ALTCS population. It allows for income garnished for child support to be included in the personal needs allowance and allows for income garnished for spousal maintenance under a judgment to be included in the personal needs allowance. This will provide a greater amount of assistance and support for this population.

IHS/638 Specialty Drug Reimbursement: AHCCCS is implementing a new methodology which we’ve gone over at previous tribal consultations regarding specialty drugs. This allows for a separate reimbursement methodology for specialty drugs which will be provided in a list and those will be compensated with a different methodology than the AIR. The methodology will be a professional fee plus the lower of the federal supply schedule unit price or wholesale acquisition cost. This should allow for greater reimbursement for those drugs than is currently available.

638 FQHCs: We’re also submitting the SPA for FQHC changes. This creates an alternative payment methodology available to 638 facilities registered as FQHC with AHCCCS. The alternative payment methodology allows for reimbursement at the AIR for all FQHC services.

Questions:

Q: *Is there a list of the drugs?*

A: *Yes, there is a list and some of the high cost drugs such as oncology drugs, Hepatitis drugs, are listed. The pharmacy workgroup that had representation from IHS/638s helped to create the list. When the list is finalized it will be posted to the website. We’ll be able to have some flexibility in changing the list in response to the needs as they come up.*

WAIVER UPDATE

Presenter: Liz Lorenz, Assistant Director, Office of Intergovernmental Relations, OIR

Waiver Update: Arizona’s last waiver expired September 30, 2016. Extension of Arizona’s 1115 waiver was approved September 30, 2016 for 5 years: October 1, 2016 – September 30, 2021. Every FFY, AHCCCS is required to give a Waiver Update. This update covers 10/1/16 to present.

Approved Waivers:

- **Targeted Investments:** A \$300M, 5-year program that funds outcomes based projects aimed at increasing care coordination and integration of physical and behavioral health services. Includes adults with behavioral health needs, children with behavioral needs and individuals transitioning from incarceration who are AHCCCS eligible.
- **Safety Net Care Pool (SNCP):** CMS approved a technical amendment to allow Phoenix Children Hospital (PCH) to make claims after 12/31/17 for expenses incurred during 2017. This does not include a programmatic

extension or any SNCP funding.

Pending Waivers: Institute for Mental and Substance Use Disorders

- **Institutions for Mental Diseases (IMD):** CMS managed care regulations from July 2016 prohibit federal funding for stays in IMDs if the stay is more than 15 days in a calendar month that applies to adults aged 21-64. This effectively restricts Arizona's "in lieu of" authority so that stays in IMDs in lieu of more expensive settings are not reimbursed by the federal government if the stay exceeds 15 days.
- **Focus on Substance Use Disorders:** On April 12, AHCCCS submitted a waiver requesting that Arizona be exempt from the 15 day limit on federal funding for IMD stays, both for managed care and FFS populations. CMS has indicated a path forward to exempt stays in IMDs that are related to the treatment of a *substance use disorder* from the 15 day limit. We are in the midst of negotiations with CMS and expect to receive approval in the near future
- **AHCCCS Works:** On December 19, 2017, AHCCCS submitted a request to CMS to implement AHCCCS Works. To qualify for AHCCCS coverage, able-bodied adults 19-55 who are not medically frail and do not qualify for an exemption must work, for a total of at least 20 hours per week:
 - Be employed or actively seek employment;
 - Attend school; or
 - Participate in the Employment Support and Development Program.

AHCCCS Works Exemptions:

- American Indians
- Pregnant and post-partum women (through the month in which 90th day post partum occurs)
- Former Arizona foster youths up to 26
- Individuals receiving long-term disability benefits
- Individuals diagnosed with a SMI
- Full time high school, college or graduate students
- Victims of domestic violence
- Individuals who are homeless
- Parents, caretakers relatives, and foster parents
- Caregivers of a family member who is enrolled in ALTCS
- Individuals who have recently been directly impacted by a catastrophic event such as a natural disaster or death of a family member living in same household.

5-Year Lifetime Limit (SB 1092: AHCCCS must request approval for a five-year lifetime limit on AHCCCS coverage. Lifetime limit would apply to able-bodied adult's members who are subject to AHCCCS Works requirements. If approved, it would become effective on waiver approval date. The following time would not count toward the lifetime limit:

- Time during which a person received Medicaid benefits prior to waiver approval
- Time during which an individual is enrolled in AHCCCS and an AHCCCS Works exemption applies; or the individual is complying with the AHCCCS Works requirements

Prior Quarter Coverage Proposed Change: Currently, Arizona covers enrollees three months prior to the month of application if the enrollee would have been eligible at any point during those months. AHCCCS proposes limiting retroactive coverage to the month of application, consistent with pre-ACA policy.

- **Objectives:** This proposal to waive Prior Quarter Coverage promotes the objectives of the Medicaid program by:
 - Aligning Medicaid policies with commercial health insurance coverage;
 - Creating efficiencies that ensure Medicaid's sustainability for members over the long term;
 - Encouraging members to obtain and maintain health coverage, even when healthy; and
 - Encouraging members to apply for Medicaid expeditiously when they believe they meet the criteria for eligibility.

Waiver Amendment Webpage and Public Comments:

- More information about proposed waiver amendment, including proposed waiver applications, public notices, and information about the public comment process, can be found on the AHCCCS website at:

- <https://www.azahcccs.gov/Resources/Federal/PendingWaivers/priorquartercoveragewaiveramendment.html>
- Comments and questions about the proposed Demonstration application can also be submitted by e-mail to: PublicInput@azahcccs.gov
- Or by mail to: AHCCCS c/o Office of Intergovernmental Relations; 801 E. Jefferson Street, MD 4200, Phoenix, AZ 85034.
- All comments must be received by **February 25, 2018**.

Questions/Comments:

Q 1: *On the Substance Use Disorder (SUD), whose diagnosis is this based on?*

A 1: *We are trying to define that with CMS. The way that CMS proposed it to us was, any stay in an IMD that's related to the treatment of an SUD. It doesn't say primary diagnoses. It's unspecified right now. That's going to be part of the discussion with CMS to determine what that means.*

Q 2: *What about a dual diagnosis?*

A 2: *I would doubt there would be a reason that a dual diagnosis would change that.*

~

Q: *Does this happen to have anything to do with the Opioid epidemic?*

A: *It probably does from the federal government's perspective. That's an accurate observation. CMS did express an interest in other behavioral health conditions and to keep the conversation going.*

Meeting Adjourned at 12:30 p.m.

APPENDIX 3: PUBLIC FORUMS PRESENTATION SLIDES





Prior Quarter Coverage Waiver Amendment Proposal



Prior Quarter Coverage Proposal

- Currently, Arizona covers enrollees three months prior to the month of application if the enrollee would have been eligible at any point during those months.
- AHCCCS proposes limiting retroactive coverage to the month of application, consistent with pre-ACA policy.

Prior Quarter Coverage Proposal Objectives

- This proposal to waive Prior Quarter Coverage promotes the objectives of the Medicaid program by
 - Aligning Medicaid policies with commercial health insurance coverage;
 - Creating efficiencies that ensure Medicaid's sustainability for members over the long term;
 - Encouraging members to obtain and maintain health coverage, even when healthy; and
 - Encouraging members to apply for Medicaid expeditiously when they believe they meet the criteria for eligibility.

The Proposed Retroactive Coverage Example

- On January 1, 2018, Mary receives a routine checkup for her medical condition from a primary care physician (PCP).
- On January 31, 2018, Mary applies for AHCCCS and informs the Agency that she has unpaid medical bills from her PCP visit in January.
- If Mary qualifies for AHCCCS coverage in January, then her AHCCCS eligibility is retroactive to the first day of the month of application—i.e. January 1, 2018.
- If Mary's unpaid medical expenses in January qualify as AHCCCS covered services, then AHCCCS will reimburse Mary's provider for those services.

Prior Quarter Coverage Historical Expenditures

State Fiscal Year (SFY)	Total Expenditures
2014	\$19,809
2015	\$15,743,139
2016	\$21,708,207
2017	\$21,347,704
2018 to date*	\$11,136,736
Total	\$69,955,595

* Includes expenditures from July 1, 2017 to November 30, 2017

Waiver Amendment Webpage

- More information about proposed waiver amendment, including proposed waiver applications, public notices, and information about the public comment process, can be found on the AHCCCS website at:
- <https://www.azahcccs.gov/Resources/Federal/PendingWaivers/priorquartercoveragewaiveramendment.html>

Public Comments

- Comments and questions about the proposed Demonstration application can also be submitted by e-mail to:
PublicInput@azahcccs.gov
- Or by mail to: AHCCCS c/o Office of Intergovernmental Relations; 801 E. Jefferson Street, MD 4200, Phoenix, AZ 85034.
- All comments must be received by **February 25, 2018.**

Questions and Comments?



Thank You.



APPENDIX 4: PUBLIC COMMENT LETTERS





Health System Alliance of Arizona

February 25, 2018

Director Tom Betlach
AHCCCS
801 E. Jefferson
Phoenix, Arizona 85034

Dear Director Betlach:

The purpose of this letter is to provide comment on the proposed Waiver Amendment to remove prior quarter coverage for new AHCCCS members.

Despite the decreased number of individuals without insurance in our communities, we still have many uninsured patients who frequent our emergency departments. We make our best efforts to initiate the AHCCCS application process for those who are potentially eligible while they are in our facilities. However, if they do not qualify during the month in which they visit our facility, or if they do not complete the application process, and do not pay their medical bills, the hospital must absorb the cost of this uncompensated care.

This Waiver Amendment suggests that one of the purposes of this proposal is to “better align Medicaid policies with commercial health insurance policies”. While we can generally agree that in some instances, mirroring the practices in the commercial market with that of our Medicaid program might be appropriate, we soundly disagree that this is an appropriate policy position in this instance.

We know that our Medicaid population is more likely to be engaged in part-time and seasonal employment, and for this reason, that they are more likely to “churn” in and out of AHCCCS coverage. Should this Waiver Amendment be approved, an AHCCCS member may be unemployed one month and have AHCCCS coverage; only to obtain part-time employment the next month and lose their coverage. We also know that because this individual only works part-time, he or she will likely not have employer-sponsored health insurance coverage. For this reason, he or she will not have coverage for primary care, emergencies or other medical services- the only point of care during this period is an emergency department.

The existence of prior quarter coverage allows this individual to move in and out of employment with some assurance of coverage, provided the health care services in question were provided within a month of eligibility during the quarter prior to the individual’s application date. This serves as a valuable protection for hospitals who serve this at-risk population and helps ensure that the patients they care for continue to have a strong network of providers available to serve their communities. To that end, we would respectfully request that a fiscal analysis be conducted on the impact of the elimination of prior quarter coverage on hospitals in Arizona.

This analysis is critical to informing the impact that this proposal will have on the system of care that serves so many who still do not have access to sustainable health care coverage.

I sincerely appreciate your consideration and am happy to answer any questions or provide additional information.

Respectfully,

A handwritten signature in black ink that reads "Jennifer A. Carusetta". The signature is written in a cursive style with a large initial "J" and a distinct "A" in the middle name.

Jennifer A. Carusetta
Executive Director
Health System Alliance of Arizona

February 23, 2018

Thomas J. Betlach
Director
Arizona Health Care Cost Containment System
c/o Office of Intergovernmental Relations
801 E. Jefferson Street, MD 4200
Phoenix, AZ 85034

Re: Arizona Section 1115 Waiver Amendment Request: Draft Proposal to Waive Prior Quarter Coverage

Dear Mr. Betlach:

The American Lung Association in Arizona appreciates the opportunity to submit comments on Arizona's Section 1115 Waiver Amendment Request: Draft Proposal to Waive Prior Quarter Coverage.

The American Lung Association is the oldest voluntary public health association in the United States, currently representing the 33 million Americans living with lung diseases including asthma, lung cancer and COPD, including 838,000 Arizona residents. The Lung Association tracks patient access to treatment for tobacco cessation and asthma guidelines-based care, is on the forefront of analyzing how policies impact patient care and works to ensure lung disease patients have access to the treatment they need.

The Lung Association in Arizona believes everyone, including Medicaid enrollees, should have access to quality and affordable health coverage. Unfortunately, the waiver amendment as proposed will harm patients. We urge Arizona to withdraw the proposed Waiver Amendment.

Waiving Retroactive Eligibility

Retroactive eligibility in Medicaid prevents gaps in coverage, by covering individuals for up to 90 days (or quarter of the year) prior to the month of application, assuming the individual is eligible for Medicaid coverage during that time frame. It is common that individuals are unaware they are eligible for Medicaid until a medical event or diagnosis occurs. Retroactive eligibility allows patients who have been diagnosed with a serious illness, such as COPD or lung cancer, to begin treatment without being burdened by medical debt prior to discovered eligibility.

In the Waiver Amendment, the state failed to address in detail how eligibility determinations would be made in a timely manner. The lack of clear timeline on eligibility determinations underscores the need for retroactive eligibility; Arizona residents eligible for Medicaid could face weeks or months waiting for an eligibility determination and lacking healthcare coverage. Patients should not be left to choose between massive medical bills and treating their illness.

Additionally, Medicaid paperwork can be burdensome and often times confusing. A Medicaid enrollee may not have understood or received a notice of Medicaid Renewal and only discovered the coverage lapse when picking up a prescription or going to see their

doctor. Without retroactive eligibility, Medicaid enrollees could then face substantial costs at their doctor's office or pharmacy. For example, when Ohio was considering a similar provision in 2016, a consulting firm advised the state that hospitals could accrue as much as \$2.5 billion more in uncompensated care as a result of the waiver.ⁱ

The American Lung Association in Arizona believes healthcare should be affordable, accessible, and adequate. No patient should face medical bankruptcy for failing to complete paperwork or because the state hasn't responded in a timely fashion. The proposed Waiver Amendment would make care unaffordable or inaccessible to Medicaid patients. The Lung Association in Arizona asks the state to withdraw the proposed Waiver Amendment as it will harm patients in Arizona. Thank you for the opportunity to provide comments.

Sincerely,



Bill Pfeifer
Executive Vice President
Southwest Region

ⁱ Virgil Dickson, "Ohio Medicaid waiver could cost hospitals \$2.5 billion", Modern Healthcare, April 22, 2016. (<http://www.modernhealthcare.com/article/20160422/NEWS/160429965>)

 **Arizona NAELA**
National Academy of Elder Law Attorneys
Arizona Chapter

February 26, 2018

VIA EMAIL (publicinput@azahcccs.gov)

AHCCCS

c/o Office of Intergovernmental Relations
801 E. Jefferson Street, MD 4200
Phoenix, AZ 85034

Subject: Arizona's Proposal to End Prior Quarter Coverage

To Whom It May Concern:

Thank you for the opportunity to comment on the state's waiver to end prior quarterly coverage for AHCCCS beneficiaries, as required by federal law. The Arizona Chapter of the National Academy of Elder Law Attorneys (AzNAELA) urges you to withdraw this proposal due to the harm it will cause to individuals with disabilities, the frail elderly, and other vulnerable populations.

Section 1115 of the Social Security Act allows the U.S. Secretary of Health and Human Services to waive certain mandatory requirements of Medicaid "in the case of any experimental, pilot, or demonstration project which, in the judgment of the Secretary, is likely to assist in promoting the objectives [of Medicaid]."

The proposal seeks to end prior quarter coverage to better align AHCCCS with commercial health insurance. Yet, AHCCCS fundamentally differs from commercial health insurance in that it is not insurance. Often the need for AHCCCS is not readily apparent. For instance, individuals may receive denial of coverage by their private insurance subsequent to treatment. They may be overwhelmed by the complexity of the AHCCCS programs and slip between the cracks. For individuals to get access to ALTCS, they must have a condition that meets an institutional level of care and meet certain financial requirements. In addition, these services are not medical in nature and are not covered by commercial health insurance or even Medicare.

For individuals that require ALTCS, the transition to a nursing home is a confusing, overwhelming process for both the individual and his or her family. Because these individuals may lack capacity, many are not applying to ALTCS themselves, someone else is on their behalf. Given the complexity of the Medicaid eligibility rules, and the onerous application, it can take families time to put the application together. For instance, getting access to five years of bank records for an individual with dementia may not be an easy task.

Further, retroactive coverage helps smooth the transition into a nursing home. In many instances, families provide the bulk of long-term care until caregivers are physically,

emotionally, and financially exhausted. In the alternative, individuals may get discharged directly to a nursing home from the hospital after an emergency, such as after a disabling fall.

At the same time an individual seeks care, the nursing facility needs to ensure it gets compensated for providing those services. Without this guarantee, facilities may choose to deny these individuals access to care unless the family can pay upfront. For those that do accept patients, depending on the contractual obligations of the family caregiver, the nursing facility could sue them by claiming they should have filed the Medicaid application more swiftly, holding them personally liable for payment of services. This increase in litigation does not serve beneficiaries, their families, nor their providers.

Holding off admission may put the individual in further danger, leading to higher medical costs, likely paid-for by the state once Medicaid gets accessed. As such, we recommend you withdraw this waiver amendment.

Conclusion

We urge AHCCCS to withdraw this proposal. Waiving the requirement that AHCCCS provide retroactive coverage three months prior to the application will be detrimental to Arizonans and their families that for whatever reason may lack access to any other source of coverage. Thank you for consideration of our comments.

If you have any question please contact our administrator, Pam Carlson, of the Carlson Group. (520.270.1541 or pam@carlsongroupmgt.com)

Sincerely,



Charlotte C. Johnson, Esq.
2018 President of AzNAELA

Of Counsel, Emily R. Taylor, Attorney PLLC
2001 E Campbell Ave, Suite 203
Phoenix, AZ 85016
charlotte@emilytaylorlaw.com
t: (480) 699-3145
f: (480) 699-4894

CC: Bridget O'Brien Swartz, Esq.
David Goldfarb

William E. Morris Institute for Justice

3707 North Seventh Street, Suite 300, Phoenix, AZ 85014-5014

Phone 602-252-3432

Fax 602-257-8138

February 15, 2018

VIA EMAIL:

publicinput@azahcccs.gov

Arizona Health Care Cost
Containment System
801 East Jefferson Street
Mail Drop 4200
Phoenix, Arizona 85034

Attn: Office of Intergovernmental Relations

Re: Comments to AHCCCS Proposed
Amendment Request to Section 1115
Demonstration to Waive Prior Quarter
Coverage

Dear Office of Intergovernmental Relations:

The Arizona Center for Disability Law (“ACDL”), Arizona Center for Law in the Public Interest (“Center”), the National Health Law Program (“NHeLP”) and William E. Morris Institute for Justice (“Institute”) submit these comments to Arizona’s proposed amendment to its demonstration waiver to waive prior quarter coverage. The ACDL is the protection and advocacy program in Arizona and works on issues concerning access to health care for persons with disabilities. The Center is a public interest law firm that has a major focus on access to health care issues. NHeLP is a national program whose mission is to secure health rights for those in need. The Institute is a non-profit program that advocates on behalf of low-income Arizonans. As part of our work, we focus on public benefit programs, such as Medicaid.

The ACDL, Center, NHeLP and Institute strongly supported Arizona’s decision to restore Medicaid services to the Proposition 204 adults and to expand Medicaid to all

persons with incomes up to 138% of the federal poverty level, with income disregard of 5%. Arizona's restoration and expansion have been highly successful. Approximately 1.9 million persons are on AHCCCS as of January 2018. www.azahcccs.gov/Resources/Downloads/PopulationStatistics/2018/Jan/AHCCCS_Populations_by_Category.pdf. Of this number, 313,000 are the Proposition 204 population (0-100% of federal poverty level) and 80,300 are the adult expansion (100-133% of the federal poverty level).

AHCCCS now proposes to be allowed to waive prior quarter coverage required by 42 U.S.C. § 1396a(a)(34) and 42 C.F.R. § 435.915. Prior quarter coverage starts with the date of application and goes back three months as long as the person would have been eligible for coverage. It is hard to imagine a more unsupportive proposal. AHCCCS claims the waiver will "better align Medicaid policies with commercial health insurance coverage." This rationale makes little sense, given the substantial differences between Medicaid and commercial insurance. The principal difference is the fact that commercial insurance relies on premium payments, while Medicaid coverage is based upon a determination that a person has limited financial resources and thus cannot afford private coverage. Retroactive coverage is not allowed in commercial insurance because the program's financing relies on premium payments in advance, before a person knows the medical services that he or she may require in any particular month. The same is not true in Medicaid, which does not require premiums from its low-income beneficiaries.

For the reasons below, the ACDL, Center, NHeLP and the Institute request that AHCCCS not proceed with the proposed waiver amendment process because the substance of the amended demonstration waiver proposal has no experimental value related to the Medicaid program, will create barriers to health care and will impede, rather than promote, the objectives of the Medicaid Act.

I. Federal Requirements for a Demonstration Waiver under 42 U.S.C. § 1315: Waivers Must Promote the Objectives of the Medicaid Act and Test Experimental Goals

The Social Security Act grants the Secretary of the United States Department of Health and Human Services limited authority to waive the requirements of the Medicaid Act. The Social Security Act allows the Secretary grant a "[w]aiver of State plan requirements" in 42 U.S.C. § 1396a in the case of an "experimental, pilot, or demonstration project." 42 U.S.C. § 1315(a) ("section 1315").¹ The Secretary may only

¹ Throughout this letter, the undersigned will refer to the demonstration waiver as "section 1315" as § 1315 is the statutory cite. 42 U.S.C. § 1315.

approve a project which is “likely to assist in promoting the objectives” of the Title XIX and may only “waive compliance with any of the requirements [of the act] ... to the extent and for the period necessary” for the state to carry out the project. *Id.* This proposed waiver amendment clearly includes policies that would impede rather than promote the objectives of the Medicaid program by creating unnecessary barriers to enrollment and access to care.

Legislative history confirms that Congress meant for section 1315 projects to test experimental ideas. According to Congress, section 1315 was intended to allow only for “experimental projects designed to test out new ideas and ways of dealing with the problems of public welfare recipients” that are “to be selectively approved,” “designed to improve the techniques of administering assistance and related rehabilitative services,” and “usually cannot be statewide in operation.” S. Rep. No. 87-1589, at 19-20, *as reprinted in* 1962 U.S.C.C.A.N. 1943, 1961-62, 1962 WL 4692 (1962). *See also* H. R. Rep. No. 3982, pt. 2 at 307-08 (1981) (“States can apply to HHS for a waiver of existing law in order to test a unique approach to the delivery and financing of services to Medicaid beneficiaries.”).

In addition, the Secretary is bound by the Ninth Circuit’s precedent for any waiver requests under 42 U.S.C. § 1315. The Ninth Circuit described section 1315’s application to “experimental, pilot or demonstration” projects as follows:

The statute was not enacted to enable states to save money or to evade federal requirements but to ‘test out new ideas and ways of dealing with the problems of public welfare recipients’. [citation omitted] ... A simple benefits cut, which might save money, but has no research or experimental goal, would not satisfy this requirement.

Beno v. Shalala, 30 F.3d 1057, 1069 (9th Cir. 1994).

Any waiver request by Arizona must meet these requirements. As explained below, AHCCCS’s proposal fails to establish any demonstration value and instead is a cost saving proposal only.

II. The Waiver Amendment Proposal Serves No Experimental Purpose, Creates Barriers to Health Care and Will Impede, Not Further, the Objectives of the Medicaid Act

This waiver amendment request proposal does not serve any valid experimental purpose and, moreover, represents bad policy for low-income Arizonans and working Arizonans with disabilities who need coverage. Such a limit on access to Medicaid only creates a barrier to access to care and does not promote the objectives of the Medicaid Act. Moreover, AHCCCS proposes to limit prior quarter coverage solely to save money. AHCCCS delineates the prior quarter coverage historical expenditures for 2014-2018 and states that the proposal to waive prior quarter coverage will save Arizona \$39,431,100 in state fiscal year 2019. As explained above, a proposal to save money, is not a valid reason for a Section 1315 waiver. *See Beno*, 30 F.3d at 1069. Also,

This waiver amendment waiver proposal has no evidentiary or experimental basis and will impede not further access to care and the objectives of the Medicaid Act. Therefore, the proposed waiver should not be submitted.

Conclusion

For all the above reasons, AHCCCS should not submit the amended waiver request. As explained above, AHCCCS failed to show that the request complies with federal requirements that it be experimental and test something experimental related to the Medicaid program and further the objectives of the Medicaid Act.

Thank you for the opportunity to comment on the draft proposal. If you have any questions concerning this letter, please contact Ellen Katz at (602) 252-3432 or at eskatz@qwestoffice.net. or Rose Daly-Rooney at 520-327-9547, ext. 323.

Sincerely,

/s/

Ellen Sue Katz, on behalf of
Arizona Center for Disability Law
Arizona Center for Law in the Public Interest
The National Health Law Program
William E. Morris Institute for Justice



Thomas J. Betlach MPA, Director
Arizona Health Care Cost Containment System
801 E. Jefferson St.
Phoenix, AZ 85034

Dear Director Betlach:

On behalf of Protecting Arizona's Family Coalition and our member programs I appreciate the opportunity to present comments regarding the AHCCCS Prior Quarter Coverage Waiver Amendment. This amendment, as presented, will limit retroactive coverage to the month of application. We have concerns about this amendment and as such we strongly oppose the amendment and ask that the state of Arizona withdraw the limit on retroactive coverage.

For many Arizona families, they may only realize they and their family are eligible for coverage after they experience a health crisis and are finally in contact with a system that provides them information on eligibility. Right now, by allowing individuals and families to be retroactively covered for 3 months prior to their application AHCCCS is able to protect Arizonans from the high cost of treatment and emergency services. Even with the proposed amendment of coverage for the month of enrollment, many families who may have experienced multiple health events prior to getting coverage would still be at risk of paying heavy costs for their health care treatment. By limiting the 3-month retroactive coverage, it will have a negative impact on low-income Arizona families.

An additional benefit to the 3 month retroactive coverage is for those Arizonans who are already enrolled in AHCCCS who may have had a lapse in coverage if only because they were unaware or failed to receive a notice for redetermination. By allowing a 3 month coverage, it protects those Arizonans with an unintentional lapse in coverage seeking services for care without paying additional costs due to that lapse.

I appreciate your consideration of our comments and encourage you to withdraw the amendment regarding retroactive coverage.

Sincerely,

A handwritten signature in black ink, appearing to read "Shannon Schell".

Shannon Schell, MSW
Executive Director
Protecting Arizona's Family Coalition



2600 N. Central Ave., Suite 1860
Phoenix, AZ 85004
602.532.0137 office
602.532.0139 fax
www.AzAAP.org
TAX ID 86-0917603

Executive Committee

President

John Pope, MD, MPH, FAAP

Vice President

Gretchen Hull, MD, FAAP

Secretary

Cody Conklin-Aguilera, MD, FAAP

Treasurer

John Phillips, BSc, CPA

Immediate Past President

Delphis Richardson, MD, FAAP

Board of Directors

Rene Bartos, MD, MPH, FAAP
Rebecca Egbert, MD, FAAP
Sean Elliott, MD, FAAP
Arturo Gonzalez, MD, FAAP
Tim Jacks, DO, FAAP
Elizabeth McKenna, MD, FAAP
Steve Moul, MD, FAAP
Michael Perlstein, MD, FAAP
Mary Rimsza, MD, FAAP
Norman Saba, MD, FAAP
Jason Vargas, MD, FAAP
Ginger Ward, MAEd
Kristina Wilson, MD, FAAP

Executive Director

Anne Stafford, MA
anne@azaap.org

Programs

Child Fatality Review
Medical Services Project
Pediatric Prepared Emergency Care
Reach Out and Read

February 12, 2018

AHCCCS

c/o Office of Intergovernmental Relations
801 E. Jefferson Street, MD 4200
Phoenix, AZ 85034

Dear Director Betlach,

The Arizona Chapter of the American Academy of Pediatrics (AzAAP), a nonprofit organization representing over 1,000 pediatric professionals from across the state, dedicated to the health, safety and well-being of all Arizona infants, children, adolescents and young adults, thanks you for the opportunity to provide comments on the proposed Arizona Section 1115 Waiver Amendment Request: Draft Proposal to Waive Prior Quarter Coverage.

We write today to express our significant concerns with this proposed application. Currently, under retroactive eligibility Medicaid pays for services provided for up to 3 months before a final eligibility determination is made if an individual would have been eligible for Medicaid during that time. Arizona's proposal to eliminate retroactive eligibility for all Medicaid beneficiaries, even those who have been traditionally eligible, would create a significant barrier to affordable health care. This proposed provision will put patients and families at risk for medical debt as well as increased uncompensated care costs for hospitals.

Limiting retroactive eligibility to the month of the application date can have unintended consequences that will have a profound impact on low-income individuals. For instance, if an uninsured, but Medicaid eligible individual has a severe accident towards the end of the month, and is hospitalized, stabilized and treated before a Medicaid application can be submitted in the beginning of the following month, that individual would be responsible for tens of thousands of dollars in health care costs. Caring for a patient in this type of circumstance would be paramount, prior to determining eligibility for Medicaid coverage. In this scenario, the hospital would also be uncompensated for the care provided in the best interest of the patient. This could put hospitals, especially those in more underserved areas, at risk for cuts or closure potentially leaving entire communities with limited or no access to health care.

We are particularly concerned about the impact on this proposal on children and families. As the application does not provide for any exclusions to the elimination of retroactive coverage, it is likely that children would be impacted by this policy change. In instances where families are unaware of their child's eligibility, families could end up responsible for thousands of dollars' worth of medically necessary care, putting even more financial stress on families already living in poverty.

As the waiver request does not propose any changes to the evaluation of the demonstration, it will be impossible to learn what the impact of eliminating retroactive coverage will be for children and families in Arizona. However, in Indiana, the Centers for Medicare and Medicaid Services (CMS) did require that safe guards be put in place to protect traditionally eligible Medicaid beneficiaries when retroactive coverage was eliminated in that state. The prior claims payment program required Indiana to pay providers for services provided up to 90 days prior to the effective coverage date for some low-income parents. CMS found that



2600 N. Central Ave., Suite 1860
Phoenix, AZ 85004
602.532.0137 office
602.532.0139 fax
www.AzAAP.org
TAX ID 86-0917603

Executive Committee

President

John Pope, MD, MPH, FAAP

Vice President

Gretchen Hull, MD, FAAP

Secretary

Cody Conklin-Aguilera, MD, FAAP

Treasurer

John Phillips, BSc, CPA

Immediate Past President

Delphis Richardson, MD, FAAP

Board of Directors

Rene Bartos, MD, MPH, FAAP
Rebecca Egbert, MD, FAAP
Sean Elliott, MD, FAAP
Arturo Gonzalez, MD, FAAP
Tim Jacks, DO, FAAP
Elizabeth McKenna, MD, FAAP
Steve Moul, MD, FAAP
Michael Perlstein, MD, FAAP
Mary Rimsza, MD, FAAP
Norman Saba, MD, FAAP
Jason Vargas, MD, FAAP
Ginger Ward, MAEd
Kristina Wilson, MD, FAAP

Executive Director

Anne Stafford, MA
anne@azaap.org

Programs

Child Fatality Review
Medical Services Project
Pediatric Prepared Emergency Care
Reach Out and Read

during that program, 13.9% of beneficiaries were eligible for the prior claims payment program and that those individuals incurred costs averaging \$1,561 per person.¹

While we appreciate the state's position on encouraging those who are eligible for Medicaid to obtain coverage while they are healthy, requiring it, particularly for families whose incomes may change considerably from month-to-month, is another matter. The Medicaid program, acting as a safety net, has retroactive eligibility in place as a safeguard to ensure that our most vulnerable citizens do not face significant financial instability because of their health. Given the complexities of the Medicaid program, it is possible that Medicaid beneficiaries are simply unaware that they are eligible for the program and able to enroll. While the waiver application indicates the state will encourage "members to apply for Medicaid expeditiously when they believe they meet the criteria for eligibility" there is no specific plan for outreach designated in the proposal, nor are any resources dedicated to such efforts.

The intent of the Medicaid program is to provide needed coverage to low-income residents who cannot afford private insurance. Removing the safety net of retroactive coverage will only result in families delaying care and adding to uncompensated care costs for providers, hospitals, and our state. This change as proposed contradicts the very nature of Medicaid as a health care lifeline for those most in need.

Thank you for the opportunity to provide comments on this renewal application. We hope you take the thoughts of Arizona's pediatricians into consideration as you contemplate this proposed waiver. If you have questions regarding our concerns, please contact us at 602-532-0137 or leadership@azaap.org.

Sincerely,

John Pope, MD, FAAP
AzAAP President

Delphis Richardson, MD, FAAP
AzAAP Immediate Past President
AzAAP Advocacy Committee Chair

¹ <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-lockouts-redetermination-07292016.pdf>



Children's Action Alliance

A Voice for Arizona's Children since 1988

Board Chairman
Hon. Claudia Walters

February 25, 2018

Board of Directors
Rhonda Anderson
Maxine Brandenburg
René Diaz, EdD
Joanie Flatt
Joseph Garcia
Joseph Gaudio
Jack Gibson
Nora Hannah
Mark Kendall
Gifford Loda
Hope MacDonald LoneTree
H. Brinton Milward
Elizabeth Reich
Wendy Villa
Hon. Claudia Walters
Hon. Carolyn Warner
Greg Wells
Hon. Corey Woods
Cathleen Yu

Thomas J. Betlach M.P.A., Director
Arizona Health Care Cost Containment System
801 E. Jefferson St., MD 4100
Phoenix, Arizona 85034

Dear Director Betlach:

We appreciate the opportunity to comment on the AHCCCS Prior Quarter Coverage Waiver Amendment, which seeks to limit retroactive coverage to the month of application for all Title XIX beneficiaries. We strongly oppose this amendment – limiting retroactive coverage jeopardizes the financial well-being of beneficiaries, providers, and the state. In addition, restricting retroactive eligibility runs counter to the objectives of the Medicaid program.

Restricting retroactive eligibility does not further the objectives of the Medicaid program.

In its proposal, the State fails to explain how limiting retroactive eligibility supports Medicaid's core mission to provide health coverage to low-income people so they can get the health care services they need. The State argues that limiting retroactive coverage will meet the objectives of the Medicaid program by (1) creating efficiencies that ensure Medicaid's sustainability for members over the long term (2) encouraging members to obtain and maintain health coverage, even when healthy and (3) encouraging members to apply for Medicaid expeditiously when they believe they meet the criteria for eligibility. However, AHCCCS provides no hypothesis nor method to test whether limiting retroactive coverage will actually meet any of these claims. Moreover, the state cites a savings estimate of nearly \$40 million state and federal dollars in FY 2019, the first full year if the waiver amendment is approved. Limiting coverage and services to reduce costs is an unacceptable demonstration hypothesis - it poses no benefit to the beneficiaries' improved health or coverage. Reduced costs cited would likely be a result of restricting access to health care or payments for their provision rather than through improved health outcomes or behaviors.

Limiting 3-month retroactive coverage will harm low-income Arizona children and families.

Many individuals may only realize they are Medicaid-eligible when they experience a health event or otherwise encounter the health system. Some may have experienced a series of health events leading up to the discovery of coverage eligibility. In these cases, retroactive eligibility prevents gaps in coverage by covering individuals for up to three months before the month of Medicaid application. In this way, it shields low-income Arizonans from the high costs of unexpected emergency or unexpected treatment that may occur.

President and CEO
Dana Wolfe Naimark

Past Board Chairmen
Rhonda Anderson
Nadine Mathis Basha
David J. Bodney
Rick DeGraw
Mark DeMichele
Nora Hannah
Win Holden
Eldon Kramer
Susan Navran
Christine Nowaczyk
Dan Schweiker
Jacque Steiner (deceased)
Greg Wells

Extreme financial strain on families has a direct and significant impact on children, often contributing to toxic stress that impedes child development. Medicaid's role providing needed access to preventive care and treatment as well as a financial stability for families can help mitigate this impact for children in low income families. Limiting retroactive coverage would undermine these core benefits for children. Limiting 3-month retroactive eligibility will harm the state through increased enrollment churn on and off Medicaid coverage

Retroactive eligibility not only protects Arizonans applying for coverage, it also protects Arizonans who are currently enrolled. Consider a beneficiary who, through no fault of their own, has failed to receive a notice for redetermination. This could lead to a delay in renewal for up to three months, during which the beneficiary will be protected by retroactive coverage. Many beneficiaries do not realize their Medicaid coverage has lapsed until they try to refill a prescription, go in for a checkup, or in the worst case, experience a medical emergency. Retroactive coverage ensures that their medical services are covered until they can renew their coverage. Rural Arizonan families will be particularly impacted by restricting retroactive coverage – 34% of rural adults and 54% of rural children are covered by AHCCCS.

Without retroactive coverage, there could be costly consequences for the individual, medical providers, and the state. The increased churn on and off coverage caused by elimination of the retroactive eligibility may in fact incur additional costs over the long-term due to the diminished health of participants and increases in uncompensated care. Cost is often cited as the main reason for eliminating or limiting retroactive eligibility. However, it is more likely that retroactive eligibility relieves providers of bad debt. When the state of Ohio considered waiving retroactive eligibility in 2016, a private consulting firm advised that hospitals could wind up with as much as \$2.5 billion more in uncompensated care costs over the five-year waiver period. CMS ultimately denied the state's waiver amendment.

The state's proposal to limit 3-month retroactive coverage does not state nor test a hypothesis that furthers the goals of Medicaid. Limiting retroactive coverage provides no benefit to Medicaid-qualified individual

Sincerely,



Dana Wolfe Naimark
President and CEO

Sources:

1. <http://www.gao.gov/new.items/d11264.pdf>
2. <https://ccf.georgetown.edu/2017/06/06/state-data-on-child-health-coverage-in-small-towns-and-rural-areas/>
3. <http://medicaid.ohio.gov/Portals/0/Resources/Reports/Annual/Group-VIII-Assessment.pdf>



Arizona Section

February 23, 2018

Thomas Betlach
Director
Arizona Health Care Cost Containment System
801 East Jefferson, MD 4100
Phoenix, AZ 85034

Re: Arizona Section of ACOG's Comments in Response to Arizona Section 1115 Waiver Amendment Request: Draft Proposal to Waive Prior Quarter Coverage

Dear Director Betlach:

The Arizona Section of the American College of Obstetricians and Gynecologists (ACOG), representing more than 550 practicing obstetrician-gynecologists (ob-gyns), welcomes the opportunity to comment on the Arizona Health Care Cost Containment System's (AHCCCS) Section 1115 Waiver Amendment Request: Draft Proposal to Waive Prior Quarter Coverage. As physicians dedicated to providing quality care to women, we are deeply concerned that the implementation of this provision would place Medicaid beneficiaries at risk for financial harm and deter our patients from seeking necessary care.

Under current law, once an individual is determined eligible for Medicaid, coverage is effective on the first day of the month of application. Medicaid must also cover state plan-approved services obtained in three months prior to application if the individual would have been eligible during that period.¹ With this waiver amendment request, AHCCCS seeks to end this long-standing protection for Medicaid beneficiaries. The state argues that this proposal is in line with current practices in the private insurance market, and that it will encourage individuals to receive primary and preventive care by seeking coverage when they are healthy, instead of waiting for medical expenses to incur before seeking coverage.

However, this proposal ignores the reality that many low-income individuals do not seek health care until the need is great – not because they are irresponsible, but because they cannot afford the cost of primary or preventive care without being enrolled in Medicaid. Many low-income individuals may not know that they are eligible for Medicaid, and may not seek care for a condition they can manage without medical attention until the condition becomes unmanageable. Ending retroactive eligibility will not prevent this pattern. In fact, ending retroactive eligibility may further encourage such self-imposed rationing of care because these Medicaid-eligible beneficiaries will have less opportunity to receive coverage for any health care costs they may incur while trying to nominally address their health needs, forcing them to take even more drastic measure to avoid incurring medical bills they cannot pay.

Arizona ACOG Recommendation: Do not submit this proposed amendment to the Centers for Medicare and Medicaid Services.

On behalf of our hundreds of members and thousands of patients we care for, thank you for the opportunity to comment on Arizona's proposed amendment to its 1115 Medicaid waiver. As explained above, the Arizona Section of ACOG believes these approaches to be harmful to the health care access and service needs of Arizona Medicaid beneficiaries, in general, and Arizonan women, in particular. We are happy to work with your office to develop solutions that both improve health outcomes and reduce costs in Arizona's Medicaid program. To discuss these

recommendations further, please contact us or Elizabeth Wieand, Program Director of Payment and Delivery System Policy, at ewieand@acog.org or 202-314-2356.

Sincerely,



Katherine B. Glaser, MD, FACOG
Chair, ACOG Arizona Section



Eric M. Reuss, MD, FACOG
Vice Chair, ACOG Arizona Section



Public Forum Comment Form

Public Forum: AHCCCS Prior Quarter Waiver Amendment

Please circle the location/date of Forum.

- Flagstaff – 1/18/18
- Phoenix – 1/26/18
- Tucson – 1/29/18
- Phoenix (SMAC Meeting) – 2/7/18

Speakers will each have three (3) minutes to make verbal comments.

PLEASE PRINT CLEARLY

Name of Speaker: _____

Organization (if applicable): _____

Phone or Email Address: _____

Comments/Questions: _____

How does this ~~waiver~~ waiver affect
 prior Qtr coverage for Medicare Cost sharing
 program premium help pay assistance.

Please use the back of this page for additional comments. →

Comments can also be e-mailed to: publicinput@azahcccs.gov



National
Multiple Sclerosis
Society

February 25, 2018

Thomas J. Betlach
Director, AHCCCS
c/o Office of Intergovernmental Relations
801 E. Jefferson Street, MD 4200
Phoenix, AZ 85034

Re: Arizona Section 1115 Waiver Amendment Request: Draft Proposal to Waive Prior Quarter Coverage

Dear Mr. Betlach:

The National Multiple Sclerosis Society appreciates the opportunity to submit comments on Arizona's Section 1115 Waiver Amendment Request: Draft Proposal to Waive Prior Quarter Coverage.

Multiple sclerosis (MS) is an unpredictable, often disabling disease of the central nervous system that disrupts the flow of information within the brain, and between the brain and body. Symptoms range from numbness and tingling to blindness and paralysis. The progress, severity and specific symptoms of MS in any one person cannot yet be predicted. The Society mobilizes people and resources so that everyone affected by multiple sclerosis can live their best lives as we stop MS in its tracks, restore what has been lost and end MS forever.

The Society believes everyone, including Medicaid enrollees, should have access to quality and affordable health coverage. Unfortunately, the waiver amendment as proposed will harm patients.

Waiving Retroactive Eligibility

Retroactive eligibility in Medicaid prevents gaps in coverage, by covering individuals for up to 90 days (or quarter of the year) prior to the month of application, assuming the individual is eligible for Medicaid coverage during that time frame. It is common that individuals are unaware they are eligible for Medicaid until a medical event or diagnosis occurs. Retroactive eligibility allows patients who have been diagnosed with a serious illness, such as MS, to begin treatment without being burdened by medical debt prior to discovered eligibility. For people with MS, early successful control of disease activity appears to play a key role in preventing accumulation of disability, prolonging the ability of people with MS to remain active and protecting quality of life. Starting and staying on an MS disease-modifying therapy is one way this is accomplished, but the median price of MS disease-modifying therapies is \$80,000. Without retroactive coverage, some people may not be able to afford starting this critical therapy.

In the Waiver Amendment, the state of Arizona failed to address in detail how eligibility determinations would be made in a timely manner. The lack of clear timeline on eligibility determinations underscores the need for retroactive eligibility; Arizona residents eligible for Medicaid could face weeks or months waiting for an eligibility determination and lacking healthcare coverage. Patients should not be left to choose between massive medical bills and treating their illness.

JOIN THE MOVEMENT[®]
1100 New York Ave NW Suite 440E Washington D.C. 20005 tel +1 202 408 1500 fax +1 202 408 0696 www.nationalMSociety.org/advocacy



National
Multiple Sclerosis
Society

Additionally, Medicaid paperwork can be burdensome and often times confusing. A Medicaid enrollee may not have understood or received a notice of Medicaid Renewal and only discovered the coverage lapse when picking up a prescription or going to see their doctor. Without retroactive eligibility, Medicaid enrollees could then face substantial costs at their doctor's office or pharmacy. For example, when Ohio was considering a similar provision in 2016, a consulting firm advised the state that hospitals could accrue as much as \$2.5 billion more in uncompensated care as a result of the waiver.¹

The Society believes healthcare should be affordable, accessible, and adequate. No patient should face medical bankruptcy for failing to complete paperwork or because the state hasn't responded in a timely fashion. The proposed Waiver Amendment would make care unaffordable or inaccessible to Medicaid patients. The Society asks Arizona to withdraw the proposed Waiver Amendment as it will harm patients in Arizona. Thank you for the opportunity to provide comments.

Sincerely,

Karen A. Mariner
VP, Advocacy
National MS Society

¹ Virgil Dickson, "Ohio Medicaid waiver could cost hospitals \$2.5 billion", Modern Healthcare, April 22, 2016. (<http://www.modernhealthcare.com/article/20160422/NEWS/160429965>)



February 23, 2017

Mr. Tom Betlach
Director
Arizona Health Care Cost Containment System
801 E Jefferson St. MD 4200
Phoenix, AZ 85034

Dear Director Betlach:

On behalf of Vitalyst Health Foundation, thank you for the opportunity to provide comments on the AHCCCS Administration's proposed 1115 Waiver Amendment to waive Prior Quarter Coverage (PQC). For over 20 years, Vitalyst has been focused on improving access to care and coverage for all Arizonans. We have convened stakeholders to collectively move change, invested in local organizations to improve care and provided timely publications to help inform public policy and practice transformation. While we commend the Administration for its efforts to advance and integrate our health care system, we cannot support this proposal to eliminate PQC, as it does not align with our goal to improve access to care and coverage throughout Arizona.

We are concerned that the elimination of PQC, as proposed, will abruptly shift health care costs to Arizona's low-income children and families. According to the Proposal, PQC covered more than \$21 million of Arizonans' health care costs in FY2017 and is forecasted to cover nearly \$31 million in FY2019. In a future without such coverage, these costs would be shifted to consumers and health systems, likely resulting in increased out-of-pocket spending, medical bankruptcies and uncompensated care. Historically, this has led to health systems passing these increased costs to private insurance companies, which in turn raise rates for their beneficiaries – a phenomenon known as “the hidden health care tax.” This is a future we opposed during last summer's Congressional attempts to repeal the Affordable Care Act, and while the PQC waiver is much smaller in scale, its potential effect on health coverage is analogous.

To the extent possible, we encourage AHCCCS to publish information about the geographic, sociodemographic, AHCCCS population-type and facility-type breakdown of PQC expenditures to help inform the public input process prior to submitting the Proposal. The opportunity to understand the Proposal's implications for urban and rural areas, the young and elderly, communities of color, hospitals, health centers and various provider-types would enable a more comprehensive set of public comments and fully-informed policymaking.

If AHCCCS is granted approval to waive PQC, we urge the Administration to consider instituting a phase-out approach. According to the Proposal, waiving PQC will encourage members to 1) obtain and maintain coverage; and 2) quickly apply for Medicaid. While this may prove true, we know that behavior change requires significant time and effort. Therefore, creating a phase-out period would allow for both patients and providers to adapt and change practices as need. This approach would provide time to build awareness, plan for changes and help mitigate potential adverse impacts to consumers.

A CATALYST FOR COMMUNITY HEALTH

Finally, we are pleased to see in the Proposal that AHCCCS “will increase efforts to educate and encourage Arizona residents to apply for AHCCCS coverage.” We are eager to learn more about how AHCCCS plans to implement this enhanced outreach and we are happy to offer our assistance.

Thank you again for the opportunity to provide comment on this Proposal. Vitalyst Health Foundation stands by to answer any questions and we look forward to continuing to work with the AHCCCS Administration on improving access to care and coverage for all Arizonans.

Sincerely,

A handwritten signature in black ink, appearing to read "Suzanne Pfister". The signature is written in a cursive, flowing style.

Suzanne Pfister
President & CEO
Vitalyst Health Foundation

February 8, 2018

AHCCCS

c/o Office of Intergovernmental Relations
801 E. Jefferson Street, MD 4200
Phoenix, AZ 85034

Subject: Arizona's Proposal to End Quarterly Coverage

To Whom It May Concern:

Thank you for the opportunity to comment on the state's waiver to end prior quarterly coverage for AHCCCS beneficiaries, as required by federal law. I urge you to withdraw this proposal due to the harm it will cause to individuals with disabilities, the frail elderly, and other vulnerable populations.

Section 1115 of the Social Security Act allows the U.S. Secretary of Health and Human Services to waive certain mandatory requirements of Medicaid "in the case of any experimental, pilot, or demonstration project which, in the judgment of the Secretary, is likely to assist in promoting the objectives [of Medicaid]."

For individuals that require Arizona Long Term Care System (ALTCS) benefits, the transition to a nursing home is a confusing, overwhelming process for both the individual and their family. Because these individuals may lack capacity, many are not applying for ALTCS benefits themselves; someone else is doing so on their behalf. Given the complexity of the Medicaid eligibility rules, and the onerous application, it can take families time to put the application together. For instance, getting access to several years of bank records for an individual with dementia may not be an easy task.

Further, retroactive coverage helps smooth the transition into a nursing home. In many instances, families provide the bulk of long-term care until caregivers are physically, emotionally, and financially exhausted. In the alternative, individuals may get discharged directly to a nursing home from the hospital after an emergency, such as after a disabling fall.

At the same time an individual seeks care, the nursing facility needs to ensure it gets compensated for providing those services. Without this guarantee, facilities may choose to deny these individuals access to care unless the family can pay upfront. For those that do accept patients, depending on the contractual obligations of the family caregiver, the nursing facility could sue them by claiming they should have filed the Medicaid application more swiftly, holding them personally liable for payment of services. This increase in litigation does not serve beneficiaries, their families, nor their providers.

Holding off admission may put the individual in further danger, leading to higher medical costs, likely paid-for by the state once Medicaid gets accessed. As such, we recommend you withdraw this waiver amendment.

Conclusion

Thank you for consideration of these comments. I urge Arizona to withdraw this proposal. If you have any question, please contact me.

Sincerely,

A handwritten signature in cursive script that reads "Catherine Shumard".

Catherine Shumard
5738 N 24th Street
Phoenix, AZ 85016
602-908-6011

shumard@cox.net

Treasurer, Board of Directors, Area Agency on Aging, Region One, Inc.

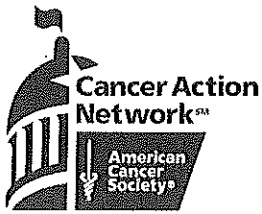
cc:

Senator Kate Brophy McGee

Representative Maria Syms

Representative Kelli Butler

Governor Doug Ducey



American Cancer Society
Cancer Action Network
4550 E Bell Rd, Suite 126
Phoenix, AZ 85032
602.586.7414
www.acscan.org/az

February 20, 2018

Thomas J. Betlach
Director
Arizona Health Care Cost Containment System (AHCCCS)
c/o Office of Intergovernmental Relations
801 E. Jefferson Street, MD 4200
Phoenix, AZ 85034

Re: Arizona Section 1115 Waiver Draft Proposal to Waive Prior Quarter Coverage

Dear Director Betlach:

The American Cancer Society Cancer Action Network (ACS CAN) appreciates the opportunity to comment on Arizona's Draft Section 1115 Waiver Amendment Request to waiver retroactive eligibility. ACS CAN, the nonprofit, nonpartisan advocacy affiliate of the American Cancer Society, supports evidence-based policy and legislative solutions designed to eliminate cancer as a major health problem. As the nation's leading advocate for public policies that help to defeat cancer, ACS CAN ensures that cancer patients, survivors, and their families have a voice in public policy matters at all levels of government.

Nearly 35,000 Arizonans are expected to be newly diagnosed with cancer this year¹ - many of whom are receiving health care coverage through the Arizona Health Care Cost Containment System (AHCCCS), the state's Medicaid program. We are concerned that the proposal to waive retroactive eligibility for new AHCCCS members could adversely impact the ability of low-income Arizonans – including many cancer patients and survivors – to access timely, appropriate, and affordable health care. We strongly urge the AHCCCS Administration ("the Administration") to address the concerns we and other stakeholders have below or reject this waiver in its current form.

Policies that would reduce or eliminate retroactive eligibility could place a substantial financial burden on enrollees and cause significant disruptions in care, particularly for individuals battling cancer. As a safety net program, Medicaid allows enrollees to receive coverage retroactively if they did not realize they were eligible for coverage under the program or while

¹ American Cancer Society. Cancer Facts & Figures: 2018. Atlanta: American Cancer Society, 2018.

they prepare the proper documentation and application to become enrolled in the program. Many uninsured or underinsured individuals who are newly diagnosed with a chronic condition do not receive recommended services and follow-up care because of cost.² In 2016, one in five uninsured adults went without care because of cost.³ Waiving retroactive eligibility could delay necessary care in low-income populations and negatively impact patients with complex medical conditions that require frequent follow-up and maintenance visits to help control their disease process.

We are pleased to see that the state intends to increase efforts to educate and encourage Arizonans to apply for AHCCCS coverage. However, we remain concerned that even with education, some Arizonans eligible for AHCCCS may not realize or be properly informed that they are eligible and could be stuck with large medical bills they are unable to pay, pushing them further into poverty.

Safety net hospitals and providers also rely on retroactive eligibility for reimbursement of provided services, allowing these facilities to keep the doors open. For example, the Emergency Medical Treatment and Labor Act (EMTALA) requires emergency departments (ED) to stabilize and treat individuals in their emergency room, regardless of their insurance status or ability to pay.⁴ Retroactive eligibility allows hospitals to be reimbursed if the individual treated is eligible for AHCCCS coverage. Likewise, Federally Qualified Health Centers (FQHCs) offer services to all persons, regardless of that person's ability to pay or insurance status.⁵ Community health centers also play a large role in ensuring low-income individuals receive cancer screenings, helping to save the state of Arizona from the high costs of later stage cancer diagnosis and treatment. Therefore, we urge the Administration to consider these providers and their contribution to Arizona's safety net, as well as the patients who rely on AHCCCS for health care coverage, when considering whether to continue with waiving retroactive eligibility in AHCCCS.

Conclusion

We appreciate the opportunity to provide comments on Arizona's draft demonstration waiver amendment. The preservation of eligibility and coverage through AHCCCS remains critically important for many low-income Arizonans who depend on the program for cancer prevention, early detection, diagnostic, and treatment services. Upon further consideration of the policy to waive retroactive eligibility, we ask the AHCCCS Administration to weigh the impact this policy

² Hadley J. Insurance coverage, medical care use, and short-term health changes following an unintentional injury or the onset of a chronic condition. *JAMA*. 2007; 297(10): 1073-84.

³ The Henry J. Kaiser Family Foundation. Key facts about the uninsured population. Updated November 29, 2017. Accessed February 2018. <https://www.kff.org/uninsured/fact-sheet/key-facts-about-the-uninsured-population/>.

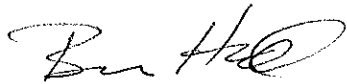
⁴ Centers for Medicare & Medicaid Services. Emergency medical treatment & labor act (EMTALA). Updated March 2012. Accessed February 2018. <https://www.cms.gov/regulations-and-guidance/legislation/emtala/>.

⁵ National Association of Community Health Centers. Maine health center fact sheet. Published March 2017. Accessed February 2018. http://www.nachc.org/wp-content/uploads/2016/03/ME_17.pdf.

may have on access to lifesaving health care coverage, particularly for those individuals with cancer, cancer survivors, and those who will be diagnosed with cancer during their lifetime.

Maintaining access to quality, affordable, accessible, and comprehensive health care coverage and services is a matter of life and survivorship for thousands of low-income cancer patients and survivors, and we look forward to working with the Administration to ensure that all Arizonans are positioned to win the fight against cancer. If you have any questions, please feel free to contact me at brian.hummell@cancer.org or 602.586.7414.

Sincerely,

A handwritten signature in black ink, appearing to read "Brian Hummell". The signature is fluid and cursive, with the first name "Brian" and last name "Hummell" clearly distinguishable.

Brian Hummell
Arizona Government Relations Director
American Cancer Society Cancer Action Network (ACS CAN)

Subject: AHCCCS Prior Quarter Coverage Waiver Amendment
Date: Tuesday, January 23, 2018 5:11:34 AM

To Whom It May Concern:

I would like to comment on: The Arizona Health Care Cost Containment System (AHCCCS) is requesting a waiver of the requirement to provide three months of retroactive coverage to new AHCCCS members. AHCCCS is seeking the flexibility to limit retroactive coverage to the month of application, consistent with Arizona's policy prior to passage of the Affordable Care Act.

This is acceptable with the following caveat: As currently set up, an application can be denied for any of several reasons that have nothing to do with the applicant's actual qualifications for participating in the program. For instance, someone can be denied benefits on an application because the submitted documents weren't quite what was needed. When this happens, the applicant doesn't find out until the application review process has completed and since the document submission deadline has passed, the applicant must start a new application. Assuming this new application is approved, the date on said application may put otherwise covered expenses outside the coverage period (being more than a month old); this needs to be corrected.

To restate: the one month coverage period should be from the point of the FIRST application for coverage, not from the date of subsequent applications for coverage that had to be created because a previous application was denied.

Thank you for your time and attention.

From: [Marie A. Keyonnie](#)
To: [Public Input](#)
Subject: AHCCCS Prior Quarter Coverage Waiver Amendment
Date: Friday, February 23, 2018 5:54:42 PM

In 1868, a treaty was signed between the United States of America and the Navajo Tribe of Indians through which the federal government is obligated and responsible to provide health care for the Navajo people. The Navajo Nation is the largest federally-recognized American Indian Tribe in the US of America with a population of 320,000. The per capita income is one third of the U.S. Almost half of Navajo families live below poverty level. In addition to the struggles with poverty levels, the Nation continues to face many challenges with health care funding, access to health care, health status, remoteness and ruralness, infrastructure and health facilities, and essential service gaps. With essential service gaps, there are limited specialized health care services on Navajo Nation. Only a portion will be referred out using the extremely limited Contract Health Services program funds. If a Navajo person that is affected by some of these factors and limitations, how will services be paid for if they should end up with a prior quarter hospital costs if it is taken away? Furthermore, prior quarter coverage is in alignment with the Affordable Care Act; so, keep it the way it is for the sake of our people.

1) The amendment if passed will limit retroactive coverage to the month of application for all Title XIX beneficiaries. This limit could financially hurt [#AHCCCS](#) beneficiaries and their families;

2) Retroactive coverage under [#AHCCCS](#) prevents gaps in coverage by covering individuals for up to three months before the month of Medicaid application;

3) The benefit of retroactive coverage shields low-income residents in [#AZ](#) from the high costs of unexpected emergency treatment;

4) Retroactive [#AHCCCS](#) coverage also prevents doctors from not receiving payment for the medical care provided to AHCCCS beneficiaries and their families;

5) Hospitals such as [@TMCChild](#) & [@NWMedicalTucson](#) are protected from debts due to uncompensated medical care in the millions of dollars from [#AHCCCS](#) beneficiaries when retroactive coverage is in place;

6) Limiting retroactive coverage could put patients at serious health risk by preventing their access to health care. Also, providers and hospitals could be financially harmed if retroactive coverage for [#AHCCCS](#) beneficiaries is restricted;

7) I hope Mr. Betlach and the [@AHCCCSgov](#) team will consider both the financial and health risks of limiting retroactive coverage for [#AHCCCS](#) beneficiaries and their families (end);

8) P.S. - Thank you, by the way, for making [#AHCCCS](#) in [#AZ](#) a success as one of the most cost-

Subject:

[Comments to Prior Quarter Coverage proposed changes](#)

Date:

Sunday, February 25, 2018 4:33:46 PM

Prior quarter coverage changes comments.

The objective in the draft proposal to limit prior quarter coverage is conjecture. Objective 2) from the draft states “encouraging members to obtain and maintain health coverage, even when healthy” has many factors. Being able to maintain health coverage includes factors such as affordability, knowledge, necessity, and more. Knowing about consequences of Medicaid policy is not a factor in maintaining healthcare coverage. Where is the theory and partial evidence this demonstration waiver will build upon? Furthermore the relationship between efficiencies and sustainability, as written for objective 1), is a reach at best.

I would like to see data from AHCCCS that identifies beyond ‘dollars saved’ the impact on vulnerable populations. What Medicaid categories, demographics and conditions precede, those affected by removal of prior quarter coverage. Knowing that data, would help in preventing the necessity of prior quarter coverage and the scope of who and why.

I do not support the proposal as written.

Subject: Comments to waiver proposal
Date: Thursday, January 4, 2018 4:56:42 PM

I'm very against to making changes to AHCCCS for many reasons. We just can't deny health care to anyone that needs it. We and You can't be that heartless. When the current plan is helping many people stay well. We tax payers will eventually end up with paying through our own medical health insurance and pharmsuical cost if these changes occur.

You mention schooling and job training. People need financial assistance to attend a school, plus student loans are very high. Some don't even have the income to pay back a loan. Is Arizona going to provide job training for those able bodied people and provide scholarships for people that want to go to school? People on AHCCCS are usually people who are very low income. If AZ is going to provide these funds, they need the public to know where to apply.

Another issue is there are many people who have come out of detention center and employers don't want to take the chance to give these people a chance to prove they can be a good employee.

Then, what happens to the people addicted to some kind of substance, do they fall under mentally and physically unable to work? Are you going to omit them?

What about those people who work minimum wage and by just a few dollars pass to qualify for AHCCCS and can't afford Obama Care?

Are you going to provide the resources to determine who is mentally or disable able to work?

You and I are very fortunate to be able to afford our Medical Insurance, we just can't abandon them and their need for this intidment.

There are many variables to think about. We can't just be cutting people off who deserver medical health to stay well.

Another thing to think about is if these people don't have AHCCCS it's going to put a burden on hospitals, and guess who is going to pay for those uninsureded?

Let's not be hasty, think it out!

Sent from [Mail](#) for Windows 10

Subject: Do not implement waiver of three months retroactive AHCCCS coverage
Date: Thursday, February 15, 2018 10:20:11 AM

To whom it may concern:

Please do not apply for or implement a waiver to avoid paying three months retroactive Medicaid coverage for people when they need it the very most. While the AZ state coffers may benefit somewhat from a waiver, every single person who has a sudden, unexpected illness and is too poor to pay for treatment during that time, will be impacted in horrific ways. A severe accident, a heart attack, a stroke, or any other sudden serious illness prevents people from earning money. The working poor are the people who are especially at risk during this initial period. Most do not receive pay unless they are on the job. Being on the edge of poverty in the first place due to low wages and lack of employment-based medical benefits, these people who have a unexpected illness, and their children, may even become homeless during such an episode. The additional debt that will accrue during the unexpected illness, before they even know they need or want Medicaid, can lead to their total demise. PLEASE don't treat the poorest of our friends and neighbors with such cavalier cruelty.

Please do not apply for or implement a waiver to prevent three months of retroactive Medicaid (AHCCCS) coverage for those amongst us who most need public financial assistance and compassion.

Subject: RE: prior quarter coverage waiver

Dear Director Betlach:

On behalf of the non-profit and faith-based ALTCS providers in Arizona, AZ Leading Age and Covenant Health Network would like to endorse the comments made by Kathleen Pagels and the Arizona Health Care Assoc.in regard to the CMS waiver request for limitation of Provider Quarter Coverage for ALTCS applicants.

Collection of resident Share of Cost has been an ongoing challenge for the ALTCS Provider community,since that function was transferred to them from the ALTCS Program Contractors. Elimination of PQC would magnify the volume of uncollectible residents financial contribution to their care,as typically when any retroactive coverage has been approved,the residents funds over the ALTCS asset ceiling have been long expended,exhausted or spent by their family representative.

Our own information has indicated that CMS exceeded their statutory authority in granting PQC waivers,in light of the requirements of the ACA. Be that as it may,the financial impact to the Arizona ALTCS providers would be negative and material,should the retro period be reduced from 90 to 30 days.

Please reconsider this program modification,which occurs at a time when the providers are struggling with a variety of beyond inflationary cost increases promulgated by the CMS Requirements of Participation implementation obligations,as well as the work force retention and recruitment challenges triggered by the significant increase to the Arizona Minimum Wage.

Thank you for your time and consideration in this important matter.

To:
Date:

[Public Input](#)
Wednesday, January 24, 2018 10:33:53 AM

To Whom It May Concern,

I am writing to express my concerns regarding the AHCCCS proposal to end "prior quarter coverage." I urge you to require a 6 month or 1-year limit on the waiver and make final approval conditional upon an evaluation of the impact on hospitals' and community providers' uncompensated care burden as well as the effect on consumer medical debt and gaps in coverage prior to enrollment.

Thank you very much for your consideration of my concerns.

Subject: opposition to medicaid prior quarter coverage waiver
Date: Monday, February 26, 2018 2:35:36 PM

February 26, 2018

AHCCCS
c/o Office of Intergovernmental Relations
801 E. Jefferson Street, MD 4200
Phoenix, AZ 85034

Re: Opposition to Medicaid Prior Quarter Coverage Waiver Amendment

Dear AHCCCS:

I write to oppose the proposal to waive the federal protection that provides up to three months of retroactive Medicaid coverage for Arizona Health Care Cost Containment System (AHCCCS) members. Under the proposal, AHCCCS could provide coverage only as far back as the first day of the month of application.

Retroactive Coverage Is Vital to Many Consumers.

Health care needs can be unpredictable. No one can predict a stroke, a car accident, or a fall leading to a broken hip. Once a person finds herself in a hospital or nursing home, she may not be healthy enough to file a Medicaid application, or may not understand that a Medicaid application should be filed. Furthermore, the process of preparing a Medicaid application may require many weeks — for example, an application for Medicaid nursing home coverage may require submitting five years of bank statements.

To protect consumers in situations such as these, federal Medicaid law requires that Medicaid coverage be retroactive up to three months prior to the application month, if the applicant met Medicaid eligibility standards for the month(s) in question. This protection ensures that persons are not saddled with uncovered medical bills just because they received care close to the end of a month, and/or they were not able, due to medical condition or otherwise, to promptly file a Medicaid application.

The Proposal is Wrongly Based on an Illogical Comparison to Commercial Insurance.

The waiver request states that a purpose of this proposal is “[t]o better align Medicaid policies with commercial health insurance coverage.” This reasoning makes little sense, given the substantial differences between Medicaid and commercial insurance. Commercial insurance relies on premium payments, while Medicaid coverage is based upon a person having limited financial resources and thus not being able to afford commercial coverage. Retroactive coverage is not allowed in commercial insurance because the program’s financing relies on premium payments in advance. The same is not true in Medicaid, which does not require premiums from its low-income beneficiaries.

The Proposed Waiver Would Fail to Promote the Medicaid Program's Objectives.

Under federal law, Medicaid demonstration waivers are allowed only if they are "likely to assist in promoting the objectives" of the Medicaid program. This proposal fails to meet this standard. The application does not identify a specific proposition to be tested. A reader can infer a test of whether elimination of retroactive coverage would encourage Arizonans to maintain coverage and apply for Medicaid as soon as they are eligible, but such a test would be contrary to the Medicaid program's objective to protect low-income persons who otherwise cannot afford needed health care.

In addition, as discussed above, even if a person is able to start preparing an application for Medicaid as soon as they are eligible, the process may take weeks or months. Waivers should be used to improve coverage, not to leave Medicaid-eligible persons without coverage when they have health care needs, especially when those needs are unpredictable.

Crucially, retroactive coverage only applies in months when the person cannot afford to pay for health care or commercial health insurance. The only "benefit" to the state of this proposal is a reduction in Medicaid expenditures, but that reduction is accomplished by denying health care coverage to persons who desperately need it.

Conclusion.

Thank you for considering these comments. I urge AHCCCS to abandon this amendment — it would harm the low-income Arizonans that the Medicaid program should be protecting.

Subject: Please don't waive the retroactive period!
Date: Monday, February 26, 2018 4:06:17 PM

I am a volunteer ombudsman and see on a regular basis how this waiver would impact the lives of residents of Arizona Skilled Nursing Facilities! These people are under enough stress already and do not need this!

Subject: Prior Quarter Coverage Waiver Amendment comments
Date: Sunday, February 25, 2018 6:25:18 PM
Attachments: [ProudMemberLogoFinalWebJPG.jpg](#)

Arizona Healthcare Cost Containment System (AHCCCS)
c/o Office of Intergovernmental Relations
801 E. Jefferson St., MD 4200
Phoenix, AZ 85034

Dear Office of Intergovernmental Relations Staff:

The National Association of Social Workers Arizona Chapter (NASWAZ) writes today to express our concerns about the Section 1115 waiver being sought that would **eliminate prior quarter coverage** for AHCCCS members.

We outline below two major concerns with the proposal as it was presented.

First, as advocates for individuals and families served by AHCCCS, we think this proposal will have an adverse impact on the financial viability of your enrollees. We fear a return to individuals and families being forced to seek bankruptcy relief for medical bills incurred during that prior quarter, especially for families who: are not insured by their employer; have irregular or episodic work hours; and who are not enrolled in AHCCCS or Marketplace plans. According to Consumer Reports, bankruptcy filings fell by about 50 percent between 2010 and 2016. We believe that reduction was, in large part, due to the expansion of Medicaid programs in many states, as well as the implementation of the Affordable Care Act. Elimination of prior quarter coverage is very likely to reverse the trend on medical bill bankruptcies. We do not want to return to those times.

Second, we have found studies that demonstrate that uninsured individuals are less likely to receive preventive care and services for major health conditions and chronic diseases. Additionally, some individuals will fail to obtain all recommended services. According to the Kaiser Family Foundation analysis of the 2016 National Health Interview Survey, uninsured nonelderly adults were **three** times as likely as adults with private coverage to have postponed or not received need care due to costs. When care is finally sought, the cost incurred by the “system”, including AHCCCS, will simply be higher. Sadly, we will see individuals dealing with their emergent care needs in the higher cost settings of hospital emergency departments or be admitted for care. The hoped “bending of the cost curve” will not occur should that be the outcome.

NASWAZ respectfully requests that CMS deny this waiver. We have work to do to empower our families and our communities -- let's focus on those priorities.

In closing, we request CMS, if they do approve this waiver, that they require AHCCCS to: 1) conduct an aggressive community education and outreach program so people who may be eligible can indeed apply and enroll to receive necessary health care; and, 2) evaluate the growth in bankruptcies among individuals and families before and after the waiver to assess its impact on the financial viability of individuals and families in Arizona.

Subject: Prior Quarter Coverage Waiver
Date: Friday, February 16, 2018 11:32:57 AM
Attachments: [image003.jpg](#)

AHCCCS Administration,

As a concerned community medical provider I implore you to reconsider implementing a change to prior quarter coverage. The costs of care will most likely be shifted to the provider community. In most cases we find that our patients qualified for prior AHCCCS coverage but were delayed in applying related to education, knowledge, resources, etc. These 3 months of coverage are significant. The difference in one month of no coverage can be thousands of lost dollars in care to community providers especially oncology providers and delay much needed care to your members our patients and AZ residents. It is irrational to believe that this will encourage those needing AHCCCS to apply sooner. Most do not understand AHCCCS eligibility requirements or benefits well enough to wait knowing they will get any prior coverage anyways. I am aware that hospitals have SW and AHCCCS specialists and AHCCCS does education and “advertising” associated unemployment, Food Stamps, inner city clinics and the like but I would recommend a better, or a complimentary education program to demographics that are falling just outside of the AHCCCS requirements or other at risk community that are not considered the normal Medicaid population:

1. Under employed but insured
2. Self-employed
3. Students
4. Churches that (although not intentionally) tend to serve a greater # of middle income families and individuals due simply to physical location

Subject: prior quarter coverage waiver
Date: Monday, February 19, 2018 2:14:07 PM

Director Betlach-

Thank you so much for the opportunity to address this important issue.

I am writing to ask you to reconsider your request for a waiver of prior quarter coverage for eligibility for ALTCS. I am specifically asking you to exclude the ALTCS portion of the population where skilled nursing facility (SNF) costs for high acuity patients can be exorbitant and burdensome to facilities unable to collect on care they have provided for residents in good faith. We believe that the negative impact of this waiver is much greater in the long term care setting, than in the acute side for PCP visit expenses, which is the example often used to discuss impact. It might be helpful to analyze what percentage of the total expenditures (\$70 million since 2014) for prior quarter coverage (PQC) were for ALTCS members in SNFs? We believe it is a small but significantly valuable proportion.

There is no other setting that is impacted by PQC in the same manner as the SNF- most applicants do not apply for PQC when in home and community-based settings. However an ALTCS denial when in a SNF, incurring average cost of care \$6600/month, makes the impact of the denial more financially staggering. This makes PQC the last chance for the facility to gain coverage after denial- if a successful application can be completed... and many times it takes more than one effort.

One of the "objectives" stated for the waiver, is to encourage members to apply for Medicaid expeditiously when they believe they meet the criteria for eligibility - unfortunately, the fact that over 75% (*Statistics provided by AHCCCS / Office of Medical Policy & Programs, OOD, 2015*) of all applications are denied, illustrates that regardless of the "encouragement" to apply a large percentage of the applicants fail to get approved even though they are "otherwise" eligible. This is due to or due to a myriad of issues unrelated to the actual eligibility rules. Ineligibility can be failure to adequately verify, not having someone able to handle the demands of document procurement, withdrawing application due to fear, being unable to get a third party to release information, needing to apply for other benefits and sadly due to the applicant getting incorrect information regarding policy.

Those that typically require PQC are those applicants in a skilled nursing center, who for some reason, have been denied but "should've been" eligible - these residents are being care for, often under a "ALTCS pending" status - meaning the facility is waiting for approval to receive compensation for care being provide. If the application is denied, the facility does not get reimbursed for this care- unless- they are able to reapply and ask for PCQ. Here are a few examples of this:

1. **Immanuel Campus of Care SNF-** Resident moved in for Medicare stay, unable to return home due to medical decline. Resident had no Medicare secondary, so facility started application upon admission with hopes that the copays would eventually be covered. Application denied due "failure to verify" as daughter was not able to secure necessary documentation. After the denial, three months after admission - cost of care unpaid, \$18K, a new application was filed, this time with more aggressive help with daughter to obtain what was needed. If PQC, was not offered, the resident would be found eligible, but from second application forward, costing

the facility Medicaid bad debt of \$18K. However, since this resident was "otherwise eligible" and the barrier to eligibility was just a daughter's inability to obtain documents, the PQC was approved, facility was then reimbursed for care from the Medicare copays through current. The resident would not have been negatively impacted had the PQC not been granted, as they received necessary and essential care the whole time, it would be the facility, not getting properly reimbursed that would absorb this devastating financial burden.

2. **North Mountain SNF** - Resident was given inaccurate information about eligibility and was denied for prior quarter by the eligibility worker. When questioned and a supervisor looked at it, he was approved for prior quarter. His initial application was sadly not started until October 2017 by the facility social worker, but he had bills that he needed help with in September of 2017. The resident would have needed to pay about \$12,000 in medical costs (that he didn't have) and the facility would have lost that \$12,000. No fault of the resident, but he would have been penalized for receiving inaccurate information and eligibility determination by the facility social worker and an AHCCCS eligibility worker.
3. **Devon Gables SNF** - Well spouse applied for ALTCS, eventually denied due to being over \$1000 of resource limit. Limited education and guidance was provided to well spouse regarding spend down rules. The \$1000 could have easily been spent on care costs, but eligibility worker didn't offer this insight, and rather just denied case and told well spouse to "reapply". Without prior quarter coverage facility will not be able to get reimbursed for this care with new application having to write off \$45,000 for this time that should have been covered.

The common theme in all these examples is that the facility ends up being penalized for the applicant being denied, even though otherwise eligible due to improperly filed or managed application. Without prior-quarter coverage, they are unable to get a second chance to receive payment for necessary care delivered to a vulnerable patient in a long term care setting.

I appreciate the opportunity to address this important issue and am happy to provide further subject matter expertise within our membership.

Thank you for your consideration.

Subject: Protest
Date: Friday, February 16, 2018 10:54:17 AM
Attachments: [image003.jpg](#)
Importance: High

Please allow this to serve as our protest against dropping the retro coverage provision for AHCCCS patients. Many times these cancer patients need immediate treatment and the lapse in retro coverage could jeopardize their health and survival. Please consider dropping this consideration. Thank you.

Dear Mr. Betlach,

I am concerned about the CMS letter on 1/12/18 allowing states to deny medical care to vulnerable citizens. It would add unnecessary administrative expense. I entreat you to continue providing Medicaid/ACHS to all Oregonians who need it.

With a majority of enrollees already working, in school, or medically unable to work, compliance enforcement would not be cost-effective and would be a waste of money.

I thank you for your consideration.

February 23, 2018

AHCCCS
c/o Office of Intergovernmental Relations
801 E. Jefferson Street, MD 4200
Phoenix, AZ 85034

Re: Opposition to Medicaid Prior Quarter Coverage Waiver Amendment

Dear AHCCCS:

I write to oppose the proposal to waive the federal protection that provides up to three months of retroactive Medicaid coverage for Arizona Health Care Cost Containment System (AHCCCS) members. Under the proposal, AHCCCS could provide coverage only as far back as the first day of the month of application.

Retroactive Coverage Is Vital to Many Consumers.

Health care needs can be unpredictable. No one can predict (for example) a stroke, a car accident, or a fall leading to a broken hip. Once a person finds herself in a hospital or nursing home, she may not be healthy enough to file a Medicaid application, or may not understand that a Medicaid application should be filed. Furthermore, the process of preparing a Medicaid application may require many weeks — for example, an application for Medicaid nursing home coverage may require submitting five years of bank statements. As a local ombudsman covering all long-term care in the suburbs of Glendale and Peoria, I have seen first-hand the lengthy recovery and struggle—both physically and financially—of many adults needing long-term care services. Many of my residents—too many to count—require this coverage to provide treatment for them to recover and not have to endure the unnecessary stresses of an additional financial burden. We, as the great state of Arizona, should not punish our residents in need of long-term care simply because they cannot afford it.

To protect consumers in situations such as these, federal Medicaid law requires that Medicaid coverage be retroactive up to three months prior to the application month, if the applicant met Medicaid eligibility standards for the month(s) in question. This protection ensures that persons are not saddled with uncovered medical bills just because they received care close to the end of a month, and/or they were not able, due to medical condition or otherwise, to promptly file a Medicaid application.

The Proposal is Wrongly Based on an Illogical Comparison to Commercial Insurance.

The waiver request states that a purpose of this proposal is “[t]o better align Medicaid policies with commercial health insurance coverage.” This reasoning makes little sense, given the substantial differences between Medicaid and commercial insurance. Commercial insurance

relies on premium payments, while Medicaid coverage is based upon a person having limited financial resources and thus not being able to afford commercial coverage. Retroactive coverage is not allowed in commercial insurance because the program's financing relies on premium payments in advance. The same is not true in Medicaid, which does not require premiums from its low-income beneficiaries.

The Proposed Waiver Would Fail to Promote the Medicaid Program's Objectives.

Under federal law, Medicaid demonstration waivers are allowed only if they are "likely to assist in promoting the objectives" of the Medicaid program. This proposal fails to meet this standard. The application does not identify a specific proposition to be tested. A reader can infer a test of whether elimination of retroactive coverage would encourage Arizonans to maintain coverage and apply for Medicaid as soon as they are eligible, but such a test would be contrary to the Medicaid program's objective to protect low-income persons who otherwise cannot afford needed health care.

In addition, as discussed above, even if a person is able to start preparing an application for Medicaid as soon as they are eligible, the process may take weeks or months. Waivers should be used to improve coverage, not to leave Medicaid-eligible persons without coverage when they have health care needs, especially when those needs are unpredictable.

Crucially, retroactive coverage only applies in months *when the person cannot afford to pay for health care or commercial health insurance*. The only "benefit" to the state of this proposal is a reduction in Medicaid expenditures, but that reduction is accomplished by denying health care coverage to persons who desperately need it.

Conclusion.

Thank you for considering these comments. I urge AHCCCS to abandon this amendment — it would harm the low-income Arizonans that the Medicaid program should be protecting.

Subject: Waiver -Prior Quarter Coverage
Date: Wednesday, February 7, 2018 12:19:55 PM
Attachments: [Outlook-1485987249.png](#)

Greetings,

Thank you for taking time to review this comment.

The work that I do involves working with individuals in horrible medical situations. If this proposed waiver were to go through, there are numerous individuals who would be penalized for living life day to day. For example, there are many people who have major medical events happen, sometimes accidents, sometimes strokes, etc. Many of these individuals are unresponsive for a great deal of time and when they are finally able to process what is going on, sometimes several months later, they start trying to put the pieces of their lives back together. Sometimes they had insurance from their job prior to the medical event, but because they are unconscious, could not get COBRA, NOR apply for AHCCCS timely.

These individuals who get in major accidents, etc and are hospitalized for several months at a time unable to handle their own affairs will be penalized for entering the medical system. Providers, who in good faith provided medical services will not be reimbursed for their services. Individuals in these situations are often forced to file bankruptcy due to the overwhelming amount of medical debt. Medical debt is already the largest cause of bankruptcy filing. Why punish people more? There are a lot of extenuating circumstances that will cause normally responsible people not to file timely applications for coverage. Please don't take away the positive benefits that this program was meant to encapsulate.