AHCCCS
Arizona Health Care Cost Containment System

SUMMARY OF
COVID-19 PUBLIC HEALTH EMERGENCY
OPERATIONAL UNWINDING PLAN

July 14, 2022

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Background of the Public Health Emergency

Since the initiation of the of the federal declaration of the COVID-19 Public Health Emergency (PHE), the Arizona Health Care Cost Containment System (AHCCCS) implemented nearly 50 programmatic flexibilities to help ensure that members maintain access to health care services and that Arizona's provider network remains viable. These changes were implemented under a variety of federal and state authorities, and impact almost all aspects of AHCCCS delivery systems.

The PHE has also had a profound impact on AHCCCS enrollment which has increased more than 27 percent since March 2020 and crossed the 2-million-member mark for the first time in the program's history.

The PHE is currently set to expire on July 15, 2022. However, the U.S. Department of Health and Human Services (HHS) has committed to providing at least a 60-day notice prior to the official end date and, as of this publication date, no such notice has been provided.

In preparation for the end of the federal PHE, AHCCCS is offering this summary of its Unwinding Operational Plan to help inform members, providers, managed care plans, and other valued stakeholders of the changes to expect.

Federal Unwinding Guidance

To support states through this challenging transition, CMS issued guidance to Medicaid programs, providing details and requirements for unwinding each type of federal flexibility. CMS published three State Health Official (SHO) Letters specifically on the topic of unwinding federal flexibilities authorized during the PHE—SHO# 20-004, SHO# 21-002, and SHO# 22-001—in addition to tool kits, presentations, and other materials. CMS also hosted numerous all-state webinars and offered individual technical assistance calls. Because of the significant impact it will have on the AHCCCS program, the agency has taken every opportunity to partner with CMS on the unwinding efforts. The latest guidance for unwinding the PHE is posted on the CMS website.

SHO# 20-004, released on December 22, 2020, contains most of the guidance related to unwinding Medicaid flexibilities through the Disaster Relief SPA, 1135, 1115, and Appendix K processes. AHCCCS is following this guidance closely to ensure compliance with all applicable requirements. This SHO letter provides details regarding timeframes associated with each authority, and the requirements that must be followed when they expire, or if states choose to make eligible flexibilities permanent. Appendix B of SHO# 20-004 describes the specific circumstances in which the expiration of an 1135 flexibility requires advanced notice to affected members. This letter also allows for streamlining member notices by issuing a combined notice for all changes that will occur at the end of the PHE.

Unwinding AHCCCS Program Flexibilities

There are nearly 50 temporary programmatic flexibilities that AHCCCS, its managed care organizations (MCOs), providers, and other partners and stakeholders must now address in some way. Most of the flexibilities implemented during the PHE were authorized through federal pathways in partnership with the Centers for Medicare and Medicaid Services (CMS). Examples of these pathways include the Disaster Relief State Plan Amendment (DR SPA), Disaster 1135 Waiver Authority (1135), section 1115 demonstration authority, and the Appendix K process for 1915(c) Home and Community-Based Services (HCBS) waivers. Each federal authority differs in terms of the applicable policy, approval process, and unwinding requirements. The agency's requests for

federal flexibilities, and CMS' approvals, are available on the AHCCCS COVID-19 Federal Emergency Authorities Request web page.

While AHCCCS flexibilities were authorized in the form of DR SPAs and federal waiver approvals, the agency often implemented these changes through policy letters, provider bulletins, and other forms of sub-regulatory guidance. As the agency unwinds the temporary flexibilities of the PHE, AHCCCS will publish, revise, and/or rescind guidance to ensure that members, managed care plans, providers, and stakeholders understand the applicable policies and procedures that are in effect. All policy guidance specific to the PHE is posted on the AHCCCS COVID-19 Response webpage and shared with existing stakeholder groups and in community forums.

In addition to these federal authorities, federal legislation authorized significant changes to State Medicaid programs during the PHE. The Families First Coronavirus Response Act (FFCRA) authorized enhanced federal funding for Medicaid programs with a Maintenance of Eligibility (MOE) requirement that prohibits member disenrollment in most circumstances. This requirement is commonly referred to as the continuous coverage requirements under the FFCRA. The American Rescue Plan Act (ARP) extended coverage of COVID-19 vaccines and treatment services to limited benefit populations at no cost to states, and provided an enhanced funding opportunity for State Medicaid programs to spend on increasing access to HCBS.

Some flexibilities have already been terminated; others will terminate at some point after PHE ends. A few of the following flexibilities will be extended beyond the PHE and AHCCCS is actively working to negotiate others as permanent changes to policy.

Flexibilities Terminated or In Process of Being Terminated

The following COVID-19 flexibilities have already been terminated or are in the process of being terminated:

- Streamlined provider enrollment processes,
- Waiver of provider enrollment fee,
- Waiver of site visits,
- Suspension of provider revalidation processes,
- Suspension of pre-admission screening and annual resident review (PASRR) assessments,
- Waiver of processing time requirements for KidsCare applications,
- Waiver of written member consents and member signatures on plans of care, and
- Authority to delay acting on certain eligibility changes in circumstances affecting KidsCare members.

Flexibilities To Be Terminated at the End of the PHE

The following flexibilities will be terminated upon the end of the PHE:

- Continuous eligibility, including KidsCare members,
- Suspension of standard prior authorization (PA) requirements,
- Allowance to providers licensed in another state to offer emergency and non-emergency care to AHCCCS members,
- Waiver of home health service requirements, including face-to-face requirements in obtaining home health services, and allowing other provider types to order home health services,
- Modifications to standard tribal consultation processes,
- Extension of state plan paid "bed hold" days to a maximum of 30 days,
- IHS/638 facility reimbursement at the outpatient all-inclusive rate (AIR) for COVID-19 vaccine administration by registered nurses under an individual or standing order, and

- Payment for Non-Emergency Medical Transportation (NEMT) wait time services for trips associated with a COVID-19 drive-through vaccination site.

Flexibilities To Be Extended Beyond the PHE

AHCCCS is seeking authority to continue the following flexibilities indefinitely:

- Provision of home delivered meals to individuals served by the Department of Economic Security/Division of Developmental Disabilities (need CMS approval),
- Provision of personal care services in an acute care setting when an individual requires such services for communication, behavioral stabilization, etc. (need CMS approval),
- 10 percent rate increase for in-office flu vaccination codes and administration, and
- Allowing pharmacists and pharmacy interns to administer the COVID-19 and flu vaccines.

AHCCCS will continue the following flexibility for an additional 60 days following the end of the PHE:

- Waiver of premiums and other cost-sharing requirements.

AHCCCS will continue the following flexibility through March 31, 2024, under Section 9817 of the American Rescue Plan Act:

- Allowance permitting parents to provide paid care to their minor children.

Long Term Care Flexibilities

The following long term care flexibilities will expire at the end of the quarter in which the PHE ends:

- Removal of hourly service limitation (40 hours in 7-day period) for spouses who provide paid care,
- Authority to make retainer payments to habilitation and personal care providers,
- Authority to use an electronic method of service delivery: case management, personal care that requires only verbal cueing, in-home habilitation,
- Ability to conduct evaluations, assessments, and person-centered service planning meetings remotely, and
- Allowance for electronic method of sign off on required documents such as the person-centered plan.

Telehealth

While AHCCCS had already broadened its telehealth benefit prior to the pandemic, the agency implemented additional flexibilities relative to telehealth modalities via blanket waivers and DR SPAs. This enabled AHCCCS health care delivery systems to meet members' health care needs when in-person encounters were not recommended and, at times, not available. AHCCCS is exploring changes that will continue to allow additional covered services to be provided via telehealth across delivery systems when clinically appropriate. The AHCCCS Chief Medical Officer chairs a Telehealth Advisory Committee for the purposes of developing post-PHE telehealth policies. This workgroup's agendas and minutes are posted on the AHCCCS Telehealth Advisory Committee web page.

Resumption of Normal AHCCCS Eligibility Operations

Two primary factors influenced enrollment growth during the PHE: the continuous coverage requirement and a volatile labor market. The federal FFCRA requirement implemented a continuous coverage requirement, under which Medicaid members may be disenrolled only under very limited circumstances. Without naturally occurring disenrollment and attrition, enrollment has grown 27 percent since March 2020.

Additionally, difficult labor market conditions related to COVID-19 resulted in more individuals losing income, employment, and health coverage, which led to more individuals qualifying for and enrolling in Medicaid. As the continuous enrollment requirements and member protections established during the PHE begin to unwind and

normal operations resume, it is likely that AHCCCS enrollment will begin to level off and start to trend downward toward pre-PHE levels.

Under the continuous coverage requirement in the FFCRA, states are required to maintain enrollment of nearly all members through the end of the month in which the PHE ends. When continuous coverage requirements expire, states will need to conduct a full redetermination for all members who would have otherwise been subject to redetermination.

CMS has released guidance to support state Medicaid and Children's Health Insurance Program (CHIP) agencies in returning to normal operations through a series of SHO letters. SHO guidance released in December 2020, August 2021, and March 2022 sets out federal expectations and requirements related to case processing timelines and member communications for redetermining Medicaid coverage for those who had their coverage continuously maintained. The March 2022 guidance builds upon the August 2021 SHO letter, where CMS clarifies that it will consider a state in compliance with resuming normal eligibility operations if it has: (1) initiated all renewals for the state's entire Medicaid and CHIP (KidsCare) caseload by the last month of the 12-month unwinding period; and (2) completed all such actions by the end of the 14th month after the end of the PHE. CMS also clarifies that states may use information gathered during a renewal that was initiated up to two months prior to the end of the PHE to take final action in the month after the month in which the PHE ends. The PHE Unwinding Period would be 12-months, with an additional two months, totaling 14 months, to complete all outstanding eligibility and enrollment actions from the PHE. The "PHE Unwinding Period," is defined throughout this document as 12 months.

Maximizing Continuity of Coverage for Members

AHCCCS is committed to maximizing continuity of coverage for members through the course of the PHE Unwinding Period as the agency resumes normal eligibility operations. A key goal is to keep the PHE unwinding process as simple as possible. When the continuous coverage requirement expires, CMS guidance provides that states will have up to 14 months to return to normal eligibility and enrollment operations. AHCCCS expects that all member re-determinations will be completed in approximately 12 months.

Medicare Enrollment Period for Dually Eligible Members

Individuals have three opportunities to apply for Medicare: their initial enrollment period, open enrollment, and a Special Enrollment Period. Individuals who have turned 65 and are not enrolled in Social Security benefits are not automatically enrolled in Medicare and must apply. During the COVID-19 PHE, individuals may have not known they needed to, or may have chosen not to apply for Medicare during their initial enrollment period because they understood that they would not lose their AHCCCS coverage during the PHE.

On April 22, 2022, CMS issued a proposed rule to implement sections of the Consolidated Appropriations Act, 2021 (CAA) that would simplify Medicare enrollment rules. Section 120 of the CAA makes changes to Traditional Medicare by revising the effective dates of coverage and giving the Secretary of the Department of Health and Human Services (the Secretary) the authority to establish new special enrollment periods (SEPs) for individuals who meet exceptional conditions. For this population, two potential proposed SEPs would help to mitigate any gaps in coverage for this population:

- An SEP for Individuals Impacted by an Emergency or Disaster that would allow CMS to provide relief to those members who missed an enrollment opportunity because they were impacted by a disaster or other emergency as declared by a Federal, state, or local government entity.

- An SEP to Coordinate with Termination of Medicaid Coverage that would allow individuals to enroll after termination of Medicaid eligibility.

Anticipated Coverage Loss with PHE Termination

While AHCCCS has continued to process annual renewals, the agency acknowledges that there has been minimal or no contact with many members due to the suspension of disenrollment for failure to provide requested renewal information. As such, there is an inherent risk that eligible individuals may lose coverage when the continuous coverage requirement expires if they have a new address or other contact information that they have not updated since their last completed renewal. Since 2021, AHCCCS and its MCOs have made targeted efforts to reach members through social platform messages, texts, robocalls, and US mail with requests to update contact information.

Anticipated Total Disenrollments

AHCCCS has continued redeterminations throughout the PHE, which gives the agency insight as to how many members are at risk of losing Medicaid coverage when the normal redetermination process resumes. At publication date, the agency estimates that 600,000 members are at risk of losing coverage because they fall into one of two buckets: those who are factually ineligible for Medicaid coverage, and those who have not responded to the agency's requests for information in order to determine their continued eligibility.

The agency estimates that half of these members will be factually ineligible for continued Medicaid coverage. AHCCCS is working with its MCOs and 2-1-1, the Community Information and Referral Hotline, to ensure that these members are aware of other health care coverage options available from the MCOs and through the Healthcare Marketplace.

Renewal Strategies Through the Unwinding Period

A Hybrid Approach to Renewals

During the unwinding period (12 months following the end of the PHE), all AHCCCS members will undergo an automated renewal process to receive a full eligibility redetermination. Members whose eligibility cannot be renewed automatically will receive a renewal form in the US mail, documenting their information on file and the actions a member needs to take to either confirm accuracy or provide updated information and proof.

AHCCCS will prioritize renewing members who had an adverse action overridden and eligibility extended during the PHE. Renewals for households that include "overridden members" will be distributed evenly over the first nine months of the unwinding period. Within that distribution, AHCCCS will further prioritize factually ineligible overrides before compliance-related overrides, and both subgroups will be prioritized chronologically from the oldest override date to the newest.

To ensure that the renewals for the total population are distributed as evenly as possible over the 12-month unwinding period, AHCCCS will use two main strategies. First, for households that also receive SNAP benefits, AHCCCS will align renewals with the SNAP recertification. Secondly, for households whose members do not all have the same assigned renewal date, AHCCCS will identify the member whose assigned renewal month has the fewest renewals and align the rest of the household to that month.

Federal Eligibility-Related Flexibilities

With the complexity of the PHE unwind, AHCCCS has submitted numerous federal flexibilities to CMS in efforts to prepare for the significant volume of disenrollment-related actions that were not acted upon due to the continuous coverage requirements, and to mitigate coverage loss to the greatest extent possible. These flexibilities, known as Section 1902(e)(14)(A) Flexibilities are:

- Ex Parte renewal for individuals with no income and no data returned,
- Facilitating renewal for individuals with no Asset Verification System (AVS) Data returned within a reasonable time frame,
- Partnering with managed care plans to update beneficiary contact information,
- Partnering with the United States Postal Service (USPS) National Change of Address (NCOA) program to update beneficiary contact information, and
- Extended timeframe to take final administrative action on fair hearing requests.

PHE Unwind Communication Campaign

To ensure that eligible individuals retain coverage, the end of the PHE necessitates a coordinated, phased communication campaign to reach members with messages across multiple channels using trusted partners. As AHCCCS begins to resume normal eligibility operations, members will need to know what to expect and what to do to keep their health coverage.

Two-Phased Approach

AHCCCS has begun a multi-pronged outreach and education campaign statewide to members, advocates, MCOs, providers, and community-based organizations (CBOs), currently rolling out in two phases to prioritize and sequence strategies, tactics, and messages about the resumption of normal eligibility operations.

- Phase 1.0 – This phase is designed to encourage members to update their contact information such as: name, address, phone number, and email in www.healthearizonaplus.gov. This phase is underway.
- Phase 2.0 – This phase is designed to inform members that renewals have begun, and to watch their mail for renewal notifications. Phase 2.0 will begin 60 days prior to the end of the PHE. A Phase 2.0 Outreach Toolkit will be released in the future.

Mass Communication Toolkits

AHCCCS messaging toolkits, posted on AHCCCS website, provide communication support for ongoing messaging about how to prepare for the end of the continuous coverage requirement. The latest information and updated toolkits will be added to the website as they become available.

Targeted Member Communication

AHCCCS has conducted targeted outreach to members who are in “override” status for procedural reasons, encouraging them to complete a renewal prior to the PHE ending. These efforts include targeted text messaging, direct mail, robocalls, and direct phone contact.

Community Assistors

AHCCCS also works with its network of application assistors, known as HEAplus Community Assistors, to ensure members understand the importance of updating their contact information and complying with requests for additional information.

Any organization can be a Community Assistor and help individuals apply for AHCCCS. Often, assistors can reach eligible citizens in culturally and linguistically appropriate ways because they work closely with their immediate community. By being a HEAplus Community Assistor, an organization can:

- Provide personalized support to Medicaid applicants in their community,
- Help individuals apply for multiple assistance programs in one process,
- See real-time electronic verification of many eligibility factors,
- Receive a customized, detailed list of the documents needed from the applicant,
- Electronically submit an applicant's documents to ensure quick and secure receipt, and
- Track application status, including final eligibility results, without contacting state agencies.

Role of AHCCCS MCOs

MCOs are a trusted source of member information. To underscore the importance of MCOs during the PHE Unwind, CMS released guidance in December 2021, and updated in March 2022 ("Overview of Strategic Approach to Engaging Managed Care Plans to Maximize Continuity of Coverage as States Resume Normal Eligibility and Enrollment Operations)," to highlight four key strategies to maximize continuity of coverage at the end of the PHE.

AHCCCS has met regularly with its MCOs to collaboratively:

1. Share member enrollment determination information,
2. Conduct outreach and provide support to individuals enrolled in AHCCCS during their renewal period,
3. Conduct outreach to individuals when they have lost coverage for procedural reasons (i.e., failure to provide information to complete renewal), and
4. Assist individuals to transition to and enroll in Marketplace plans if ineligible for Medicaid.

Returned Mail

AHCCCS and its MCOs have developed multiple strategies to obtain updated contact information from members who may have changed their address during the PHE. Key strategies include:

- Updated policy guidance to ensure individuals retain coverage when mail is returned with an in-state forwarding address,
- Ongoing outreach campaigns to relay the importance of sharing updated contact information in HEAPlus, AHCCCS' eligibility and enrollment system and
- Adding key messaging to state websites reminding members to update their contact information.

Stakeholder Engagement

Through the public health emergency, AHCCCS has been collaborating with various stakeholders including MCOs, advocates, and community organizations to prepare to resume normal eligibility operations and health care delivery operations once the PHE ends. The experience and expertise of workgroup participants has informed AHCCCS' plans to resume normal business activities.

Working with the Arizona Governor's Office, state policymakers, and federal partners at CMS has helped AHCCCS to adequately prepare for the unwinding period and ensure that all individuals who are eligible for Medicaid maintain their coverage.

AHCCCS has kept stakeholders informed of the latest guidance through standing and ad-hoc meetings with members, providers, tribes and tribal members, MCOs, CBOs, and other community partners. Information has also been disseminated in newsletters, email blasts, and on www.azahcccs.gov in Frequently Asked Questions. AHCCCS will continue to use these methods to inform stakeholders about the PHE unwinding process.

Federal Monitoring of the Unwinding Period

Per SHO 22-001, all states will be required to submit monthly data for a minimum of 14 months through a CMS-developed reporting template. These metrics are designed to demonstrate states' progress towards restoring timely application processing and initiating and completing renewals of eligibility for all Medicaid and CHIP enrollees consistent with the guidance outlined in SHO 22-001. Subsequent CMS guidance requires states to complete a baseline and subsequent monthly Unwinding Data Report and submit these reports to CMS per the Medicaid and CHIP Eligibility and Enrollment Data Specifications for Reporting During Unwinding. In addition, states will complete and submit to CMS a summary of the state's plans for initiating renewals for its total caseload within the state's 12-month unwinding period (Statewide Renewal Distribution Plan).