TRIBAL CONSULTATION MEETING

July 27, 2017
9:00 a.m. – 12:00 p.m. (Arizona Time)
Navajo Nation Twin Arrows Casino Resort, Meeting Room Dine CFI, Flagstaff, AZ 86004
Conference Bridge: 1-877-820-7831, Participant Passcode: 108903#

NOTIFICATION TO TRIBES:

Good Morning,

This is to announce the next AHCCCS Tribal Consultation meeting on **July 27, 2017** at the following location. The meeting is hosted by the Navajo Nation who generously will provide lunch following the meeting. The draft agenda is attached.

Twin Arrows Casino Resort (East of Flagstaff past Winona on I-40)
22181 Resort Blvd., Flagstaff, AZ 86004
Meeting Room: Dine CFI
9:00 a.m. – 12:00 p.m. (Phoenix Time)
Teleconference Number: 1-877-820-7831, Participant Passcode: 108903#

If you plan to stay at the Resort hotel, call 1-928-856-7200 to reserve a room. Mention booking ID#: 4451 (AZAHCCCS Tribal Consultation meeting). The government rate is: $143.00 plus tax. First night's lodging will be charged at the time a reservation is made.

If you will participate by phone, dial **1-877-820-7831** and enter participant code, **108903#.** Please mute your phones and do not place phones on hold as this will disrupt the meeting with music. Meeting materials will be posted to the AHCCCS website to download the day before the meeting. Click on the following link to access the Tribal Consultation page: https://www.azahcccs.gov/AmericanIndians/TribalConsultation/meetings.html.

Please inform me if leaders from your tribe will attend this meeting as it is AHCCCS practice to recognize tribal dignitaries.

Don't hesitate to contact me if you have questions. Thank you in advance for your participation in this important meeting.

Bonnie Talakte
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AHCCCS TRIBAL CONSULTATION MEETING AGENDA

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

Date: July 27, 2017
Time: 9:00 a.m. – 12:00 p.m. (Phoenix Time)
Location: Twin Arrows Casino Resort, Meeting room Dine CFI, 22181 Resort Blvd., Flagstaff, AZ 86004
Conference Call-In: 1-8977-820-7831, Participant Passcode: 108903#

TIME	TOPIC	Presenter
9:00 - 9:30 a.m.	Welcome	Thomas Betlach, AHCCCS Director
	Tribal Leader Welcome	Norman M. Begay, *HEHSC Vice-Chairman, Navajo Nation*
	Invocation	Gerald King, *Navajo Nation*
	Introductions	Director Betlach
9:30 – 9:45 a.m.	Overview of Navajo Nation Health Services	Dr. Glorinda Segay, *Executive Director, Department of Health, Navajo Nation*
9:45 – 10:45 a.m.	AHCCCS Update • Budget Implementation – Adult Emergency Dental • Repeal & Replace • Federally Qualified Health Centers (FQHCs) • Integrated Contractor RFP • Proposition 206 SPA • American Indian Medical Home Update	Director Betlach & Elizabeth Carpio, *Assistant Deputy Director*
10:45 - 11:15 a.m.	State Plan Amendment (SPA) & Traditional Healing Updates	Kyle Sawyer, *Intergovernmental Relations Specialist, Office of Intergovernmental Relations*
11:15 - 11:35 a.m.	Tribal ALTCS Intergovernmental Agreements	Markay Adams, *Assistant Director, Division of Fee-for-Service Management*
11:35–11:55 p.m.	Waiver Update	Elizabeth Lorenz, *Assistant Director, Office of Intergovernmental Relations*
11:55 - 12:00 p.m.	Wrap-Up/Adjourn	Director Betlach

MEETING ATTENDEES:

Tribes	**Hopi Tribe:** Rolanda Yoyletstewa, Al Sinquah **Navajo Nation**: Gen Holona, Theresa Galvan, Sheila Bedoni, Katherine Nelson, Roselyn Begay, Lucinda Martin, P. Herrera, Michelle Jones, Terrelene Massey, Virginia Arizona-Fat, Elinna Henderson, D. Arra, Betty John, Glorinda Segay, Michele Morris, Marie Keyonnie, Marie Begay, Mabel Charley, Antonio Ramirez, Vera John, Charlene Begay, Norman Begaye, Lucy Bancroft, Roland Todacheenie, Yvonne Kee- Billison, Miranda Blatchford, Brenetta Pine, Mark Freeland, Rosita Cody, Rose Todachinnie, Tammy Yazzie, Kenneth Begay, Georgina Crawford, Stanley Reddye, Mae-Gilene Begay, Alta white, Darvina Kaye, Alutha Yellowhair **Pascua Yaqui Tribe**: Rosa Rivera, Linda Guerrero, Raquel Avelas **San Carlos Apache Tribe**: Alex Ritchie, Victoria Stevens, David Reede, Vickie Began, Isaiah Belknap, Nella Ben, Kathy Kitcheyan, Valesquez Sneezy, **White Mountain Apache Tribe**: Lona Hinton, Shanna Antonio-Edwards, Sonia George, Jessica Rudolfo, Althea Velasquez, John Zacher, Felicia Suttle, Tammy Dozen, Bethani Thomas, Felix, Benally
I/T/Us	**Fort Defiance Indian Health Board**: Terrilynn Nez-Chee, Christine Becenti **Navajo Area IHS**: K Dempsey, Priscilla Whitethorne, Ethelyn Bailey, Alva Tom **Tuba City Regional Health Care Corporation**: Christine Keyonnie, Melverta Barlow, Melissa Humetewa, Selena Simmons, Yolanda Burke **Winslow Indian Health Care Corp.:** Roderick Antone, Sally Pete, Cecelia Jackson, Mary Billie, Jennifer Begay, Jolene Yazzie, Carol Chitwood
Other	**Arizona Advisory Council on Indian Health Care**: Kim Russell **Cenpatico**: Sheina Yellowhair **Centers for Medicare & Medicaid (CMS)**: Lane Terwilliger **Community Bridges**: Anderson Phillips **Health Choice Integrated Care (HCIC)**: Gabriel Yaiva, Holly Figueroa **InterTribal Council of Arizona**: Alida Montiel, Verna Johnson **Mercy Maricopa Integrated Care (MMIC)**: Faron Jack **Native Resource Development**: Jermiah Kanuho
AHCCCS Representatives	Thomas Betlach, Elizabeth Carpio, Elizabeth Lorenz, Bonnie Talakte, Markay Adams, Kyle Sawyer, Reuben Soliz

MEETING SUMMARY

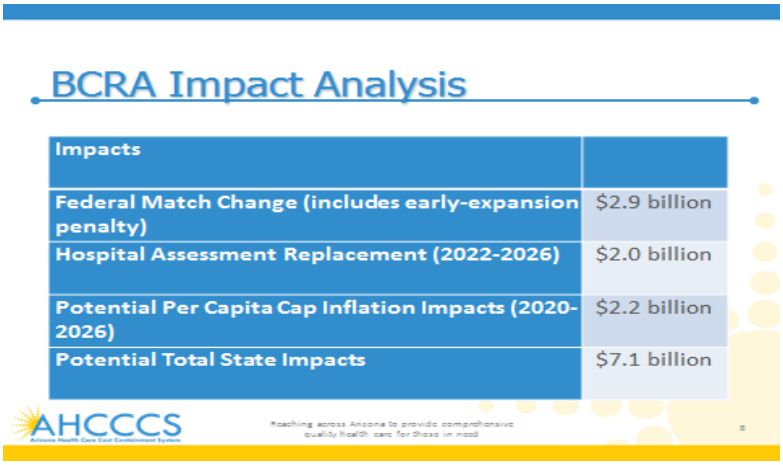
All meeting materials and presentations can be found at the AHCCCS Tribal Consultation website:
https://www.azahcccs.gov/AmericanIndians/TribalConsultation/meetings.html

TOPICS	SUMMARY
OVERVIEW OF NAVAJO NATION HEALTH SERVICES Presenter: Dr. Glorinda Segay, Executive Director Department of Health	The Navajo Nation Department of Health is a tribally operated health department. The Department is responsible for monitoring, evaluating, regulating, enforcing and coordinating health codes, regulations, policies, standards and ensuring that high quality, comprehensive, and culturally relevant health care and public health services are provided for the Navajo people. The Department is currently realigning its operations by function that include: health service, public health programs and

	regulatory and compliance oversight. The Draft Master Plan of Operations for the Department is being reviewed internally. The proposed Legislation will allow for a 5-day public comment & be put on the HEHS Committee's agenda in August 2017. The Navajo Health Care System consists of: 1. Navajo Department of Health: 14 Public Health Programs 2. Navajo Area Indian Health Service a) Area Offices-St. Michaels, Chinle, Crownpoint, Kayenta, Gallup & Shiprock Service Units 3. Navajo 638 Tribal Organizations a) Tuba City Regional Health Care Corporation—Title V Compact b) Utah Navajo Health System—Title V Compact c) Winslow Indian Health Care Center—Title V Compact d) Sage Memorial Hospital—Title I Contract e) Tsehootsoii Medical Center—Title I Contract 4. Native Traditional Practitioners 5. Private Providers
AHCCCS UPDATES Presenters: Thomas Betlach, AHCCCS Director and, Elizabeth Carpio, Assistant Deputy Director of Business Operations	**Thomas Betlach:** Tribal Consultation: When broad policy discussions around Medicaid are required with Tribal Nations and I/T/Us, the following tribal consultation notification process is implemented in keeping with AHCCCS tribal consultation policy: 6. Determine policy and programmatic changes that may impact tribal nations and I/T/Us; 7. Schedule tribal consultation to review, discuss and obtain input on polices and programmatic changes. Policies are posted on the AHCCCS website for review; 8. Provide 45 days in which comments, positions and reactions to policy and programmatic changes is obtained; 9. Tribal stakeholder input is taken into account before policies and programmatic changes are finalized. Examples were provided of consultation meetings and events that AHCCCS has engaged in with tribes during 2017. Senate Repeal and Replace: Congress has been engaged in discussions on Repeal and Replace of the Affordable Care Act for months. The house has passed legislation which has been sent to the Senate. The Senate has had two different pieces of legislation, a Replace bill that failed and a Repeal only bill that failed. Now Congress will vote on a Skinny Repeal bill which is the removal of the individual and employer mandate (which also failed). Congress will also hear a number of amendments around Repeal and Replace. As the discussions have continued at the Congressional level, AHCCCS has provided information to stakeholders, as a way to engage policy makers, that describes the impacts of the various discussions on Arizonans and tribal members. According to the House bill, starting January 1, 2020, states will no longer receive an increased match for Medicaid expansion. The increased match AHCCCS receives is 90% federal funds and 10% state funds for individuals in Medicaid expansion. The 90:10% looks to be reduced in both Senate and House bills. The decisions being made by Congress, as it relates to Repeal and Replace, have

potentially significant impacts on who is covered in the AHCCCS program going forward. It will be up to the state legislature to identify whether or not the state can continue to provide coverage to those individuals. Congress has to figure out what a final bill might look like which will go to the House and Senate for a final up or down.

BACRA Impact Analysis: BACRA is the Senate bill. The BACRA analysis describes the 3 ways the Senate bill will impact Arizona and is depicted in the following table.



Questions, Answers, Comments, Responses:

Q: What is Governor Ducey willing to live with in terms of the BCRA version?

A: 1) What Governor Ducey has communicated to Senator McCain is that he would like to see something if they are going to move forward with reducing funding for Medicaid Expansion. The State needs a much longer timeframe to be able to deal with the budgetary consequences of that. A 10-year phase down of 2% per year is something Governor Ducey believes the state can live with. He feels an incremental change would allow the state to have the time to create the budget capacity to absorb the impact. 2) The second change Governor Ducey would like to see is a higher per capita cap so that it reflects the costs of the Medicaid program and does not squeeze the Medicaid program. He would like a consumer price index for medical plus 2%. 3) Arizona expanded before the Affordable Care Act and States that did weren't treated quite equally. In fact there was a provision put in both bills where states like AZ would have to incur a payment right away and Governor Ducey would like to change that. This is the third change Governor Ducey has asked for. Senator McCain has an amendment that would do these three things.

Q: Is that available in writing and where can I find it?

A: Yes. The Senator did a press release**.** You can find it on his website.

C: One of the issues we're having currently is that AHCCCS does not provide tribes with an audit report of the revenue generated by NEMT companies. What we ask in our contracts is a request of audits from the NEMT companies. Our contracts have a percentage that the NEMT companies have to pay the tribe. It's hard to verify if the percentage is an accurate representation of the total amount of the revenue generated. We'd like to know if and when a conversation can take place with the NEMT tribal workgroup that can focus on the revenue generated on our tribes by these companies. When we go to the AHCCCS website that website has not been updated for the past 4 years it's a general overview of NEMT for the state but it does not break down by reservation.

R: I recommend reconvening the tribal NEMT workgroup for more detailed

	conversations around NEMT and data. AHCCCS is a public program and information on the overall level of spending can be made available. The challenge is it will be difficult to break out revenue for a specific area versus statewide. We would leave that up to the workgroup to determine what is and is not available. We appreciate the leadership from the White Mountain Apache Tribe for partnering with us over the past few years to try and come up with stronger polices for NEMT's. We'll go back to the workgroup and reach out to individuals who might be interested in participating. We have done audits to ensure that NEMT's have tribal business licenses but we haven't gone to that level of detail you described. **C:** The second issue is the violation of HIPPA laws by NEMT companies at WMAT. We have previously encountered an NEMT company that was not protecting patient confidentially and information. One of the most up-held standards with the Division of Health Programs at White Mountain Apache is the HIPPA standard. We regulate that standard very strictly and there are different types of consequences if violated. In my conversations with AHCCCS, we were told to contact IHS, ADHS and HHS for HIPPA information. Then I got sent to the Office of Civil Rights. We went in a giant circle. There is no follow up. There's no procedure through AHCCCS. **R 1:** There are requirements in Provider Registration that are held to the standards of HIPPA and other legal requirements. There are actions that we can take as well. **R 2:** When AHCCCS receives a complaint about a provider, the process is to refer it to the Office of Inspector General (OIG). The OIG conducts the investigation but does not provide feedback or follow-up on the investigation. OIG is a separate and apart process on purpose so that their process is protected and what is happening with a provider. **Q:** The Navajo Nation has a great concern about the senate bill regarding Medicaid expansion being capped. We're also concerned that additional funding from FMAP will be stripped away. We appreciate your support in maintaining the funds that go to IHS and 638 health programs. We're also concerned about the mandatory work requirement. On Indian lands, employment is very scarce. We have a very high unemployment rate. The requirement of this additional burden is unconscionable. We just ask that you take our concerns back to the Governor and other legislators. **A:** Thank you for your comments. There is a state statute that requires AHCCCS to submit a waiver around work requirements by March 31st. That date has come and gone and we have not submitted the waiver. We received over 400 comments from interested stakeholders when we went through our public comment period. I thank everybody that engaged in that process. We have been going back and incorporating the comments and working with the Governor's office in shaping and refining what that policy waiver submittal should look like. We are still in the midst of that process. **Q:** Can you direct me to the place on your website where I can find data and statistics on the American Indian population in the state of Arizona by county? Another question I have is what does AHCCCS receive from CMS per member per month? **A:** Information on the website relates to individuals enrolled in the American Indian Health Program which is the total number of individuals in the state, around 130,000. We have enrollment by county based on a member's address. On the website we are limited on the data we can display because of HIPPA. If we go below the county level information we need statistical validation that won't reveal member information. That requires a whole statistical analysis. We provide significant data to IHS and tribal

638 providers on members who are receiving services from a facility and outside a facility. That information is shared from a care coordination perspective. In regard to per member per month we can calculate that. That is information that is not on the website. We can follow-up with you on that.

Budget Update: The State Legislature enacted budget changes last spring. Adult emergency dental was the last benefit that AHCCCS had not restored from the great recession. That benefit was restored by the Legislature. Starting October 1, 2017 a $1,000 emergency dental benefit will be in place. Since the emergency dental benefit will be restored on October 1st, uncompensated care payments to IHS and 638 facilities will be discontinued.

Questions, Answers, Comments, Responses:

C: What is disconcerting about the emergency dental restoration is that the dental service was capped at $1000 per member per year. Previously the uncompensated care payment was not capped. What I'm concerned about is why this cap will apply to our health facilities. The dollars won't go far. We need to get to some clear understanding as to why this cap will apply to IHS/638 facilities.

R: The cap was put in place by the Legislature and that is what AHCCCS is implementing based on the October 1st requirements. We looked at some of the utilization data of emergency services before the benefit was put in place. The vast majority of cases would have been covered by the $1000 cap. There should not be a dramatic impact of having the $1000 cap in place on emergency dental. The important thing is that we will have the data and we'll be able to see the impact of the cap and if there is an impact we will to go back to the Legislature to describe the impact and quantify that to them.

Q: Can the uncompensated waiver kick in after the third visit occurs for emergency dental?

A: The uncompensated care waiver is based on a per member per month (PMPM) that is paid out to IHS and 638 facilities. In essence by the time you take that PMPM and adjust it for the restoration of those benefits you are down to a few pennies that would be paid out to IHS/638 facilities. It's probably more expensive to pay out the claim than the value of the claim associated with the uncompensated payment. A Dental benefit to pregnant women would be a brand new dental benefit that has never existed in the program before. It would be much more helpful and much better from the perspective of galvanizing energy toward advancing a new benefit than to spend the next year talking about the uncompensated care waiver and whether or not we want to pay out a few cents associated with the $1000 limit on emergency dental. For the agency, we want to put our time, effort and energy into a dental benefit for pregnant women and a few other services as part of the next budget cycle. We'd rather have a joint voice around that rather than try to work through a very minimal amount that would get paid out for emergency dental.

Occupational Therapy: Expanded occupational therapy services will be made available for the state on October 1, 2017.

Opioid Initiative: The Governor declared an emergency proclamation on opioids after receiving a report from ADHS that the number of deaths grew over 750 in 2016. AHCCCS is in the process trying to leverage Medicaid and some limited new funding to expand treatment services that can be used in combination with crisis services and expand more education for providers and make Naloxone more available in the system for first responders and others.

Proposition 206: This is the initiative to raise the minimum wage. There was also a Flagstaff wage initiative. As a result of those initiatives, AHCCCS is raising reimbursement rates for nursing facilities and home and community based services.

Elizabeth Carpio:

American Indian Medical Home (AIMH): AIMH was developed over many years with extensive Tribal and Indian health consultation. AHCCCS's waiver proposal was designed to support development of Patient Centered Medical Homes (PCMH) at IHS/Tribal 638 facilities across AZ. The proposal focuses on state-wide integrated care, secure data and health information exchange, and care coordination for AHCCCS members with complex conditions. The State Plan Amendment (SPA) was approved by CMS on June 14, 2017. The start date is, October 1, 2017.

The AIMH tribal workgroup developed the following criteria for facilities to acquire Primary Care Case Management (PCCM) designation.

- The site has achieved Patient Centered Medical Home (PCMH) recognition (NCQA, AAAHC) or
- IHS IPC program attests annually that site/organization has completed the following in the past year:
    - Submitted the SNMHI PCHM Assessment, with a score of 7 or >
    - Submitted monthly data on IPC Core Measures
    - Submitted quarterly improvement project narrative summaries
- Have a 24 hour nurse call line
- After hospital care coordination
- AIMH Member Requirements:
    - Title 19 AIHP enrolled member only
    - Participation is voluntary
    - Member may discontinue at any time
    - Member may switch AIMH at any time
    - Facility must keep signed AIMH form on file
- Implementation forums with IHS/638 facilities have been scheduled on the following dates:
    - July 6, 2017
    - August 3, 2017
    - September 6, 2017
    - October 3, 2017

Questions, Answers, Comments, Responses:

Q: San Carlos Apache Healthcare Corporation is not going to be ready by the start date of October 1st. Do we apply when we're ready?

A: Yes, we anticipate that facilities will be in readiness at different times so AHCCCS will be happy to assist with the process when you're ready.

Q: Are we required to do this? If we have the accreditation are we required to do this?

A: No, you are not required to do this. This is voluntary for members and facilities. However, if you don't apply you will not receive the additional payments**.** You can do nothing and continue to be a provider but because you already have the accreditation you can submit the application and meet the criteria and your facility will receive the additional PMPM for those members attributed to your medical home.

Q: Is the Title 19 requirement for a certain age group or all including children?
A: It's for all AIHP enrolled members.

Q If we are not able to meet all 3 tiers by October 1st, for example the HIE requirement, can we add the HIE portion of it to an amendment to the contract when we do meet that requirement?
A: Yes. The diabetes and HIE services are optional. The non-optional criteria is providing the 24/7 nurse call line and after hospital care coordination which will get you the $13.26 PMPM. If you want to add the diabetes and HIE for additional payments later you can do so.

Federally Qualified Health Centers (FQHCs):
On February 26, 2016, CMS issued a State Health Official (SHO) letter that was specific to care coordination agreements for the "received through services" of an IHS/638 facility. It was through an engagement process that CMS identified an issue that was systemic around the "four walls" limitations. CMS issued additional guidance called FAQ's on January 18, 2017 around the SHO letter for the received through services from an IHS/638 facility. The FAQ focused only on pages 5 & 6 of the initial letter and it addressed the four walls issue. If you are a facility that is registered as a clinic, the AIR is only reimbursable when the clinic services happen within the four walls of the clinic. If the services happen outside the four walls of a clinic those are not reimbursable at the AIR but are subject to the fee schedule that any other provider is subject to. CMS indicated that this is not being applied equally across most programs in most states and will begin auditing with dates of service after January 30; 2021.This will give states time to come into compliance with the four walls limitation. The relief CMS proposes, as part of the FAQ's, was specific to tribal 638 facilities and indicate that if 638's are registered as clinics, and the four walls limitation is of concern, they have the option to register with the state Medicaid agency as an Federally Qualified Health Center (FQHC) and the four walls limitation would not apply. The decision to become an FQHC lies solely with tribal 638's. If they decide to become an FQHC they have to inform their Medicaid agency and their registration can be changed. The guidance indicates that States are able to establish an Alternative Payment Method (APM) that is reflective of the AIR for tribal 638 FQHCs which has to go through a State Plan Amendment process. However, every tribal FQHC has to agree to that methodology. The guidance from CMS does not suggest that tribal 638's, which are registered as clinics, have to become FQHC's. It is their choice not a mandate.

A tribal 638 workgroup was organized to address questions and concerns on the FQHC process. The purpose of workgroup:

- For tribal 638's who are interested in changing their registration to FQHC. IHS facilities are not qualified to become FQHC's.
- Gather tribal perspectives regarding 638 FQHC issues including:
  - Definition of FQHC services vs clinic services
  - Daily visit limits
  - Reimbursement methodology
  - Four walls limitation
- Identify stakeholder questions to research
- Provide stakeholder's information regarding the FQHC vs Clinic provider type (services, reimbursement, etc.).

Questions, Answers, Comments, Responses:

Q: Does the four walls apply to hospitals?
A: It applies only to clinics.

Q: In the matrix that will be developed by the workgroup, will there be an opportunity for the workgroup to see the difference between the rates, the AIR and FQHC fee schedule rates?
A: The current FQHC rate is called a PPS rate developed related to a cost reconciliation process that's done every year. There is not a standard rate that you would see for position services. Each FQHC PPS rate may be different. What the guidance from CMS says is that 638's are not subject to the reconciliation process or not subject to submitting data. That creates a problem as to how to establish the PPS rate for 638s without that. That's when CMS gave the option to establish an APM that would be the All Inclusive Rate (AIR). For tribal 638's, they would receive the AIR for services as they do today through the APM process. When you go through an APM process everyone has to agree that the APM is the AIR.

Integrated Contractor RFP: This topic was discussed at the last Tribal Consultation meeting in April and at several forums since then. AHCCCS has been on the path to integration for some time. The RFP puts forth for consideration integration of physical and behavioral health for individuals. The RFP also examines, crisis services currently provided by RBHAs and grant funded services. Integrated healthcare for members means that you will choose a single healthcare plan that will:

- Include physical and behavioral healthcare service providers
- Manage the provider network for all of your healthcare services; FFS "Network"
- Be the single payer to providers for the services you receive

The benefits of integration:

- Ease navigation of health care services;
- Single point of accountability
- Improve a person's whole health; and
- Streamline care coordination to get to better outcomes

Supporting Choice for American Indian Members:

- Integrated choices for the **GMH/SA and Children** populations will be available within:
  - Fee-for-Service (AIHP) or (AIHP/TRBHA);*and*
  - Managed Care (Integrated Contractors)
  - American Indian members will still be able to access services from an IHS/638 facility at any time regardless of enrollment

Integrated Major Decisions:

1. Procure for Integrated Contractor Managed Care Organizations (MCOs) that will replace Acute and CRS Contractors serving the following Title XIX/XXI populations and services:
   a. Adults who have not been determined to have a Serious Mental Illness; *and*
   b. All children except for foster children enrolled with Comprehensive Medical Dental Program (CMDP).
2. Services for Members with Children's Rehabilitative Services (CRS) Qualifying Conditions:
   a. Receive integrated physical (including CRS) and behavioral health services through an integrated contractor or Fee-for-Service;
   b. Members determined to have a serious mental illness will transition to

	the regional behavioral health authority (RBHA) for integrated physical and behavioral health services or AIHP/TRBHA; *and* c. Members enrolled with CMDP will receive physical health services for their CRS condition from CMDP. 3. Crisis services will continue to be served by the RBHAs and TRBHAS. The existing RBHA geographic service areas unchanged on 10/1/18. 4. The geographic structure for integrated contractors *(not including RBHAs)* will align with the service areas established for the ALTCS contract beginning on 10/1/17 *(table on right):* **GSA Name and Corresponding Counties** North GSA Mohave/Coconino/Apache/Navajo/Yavapai (excluding zip codes 85542, 85192, and 85550) South GSA Cochise/Graham/Greenlee/ La Paz/Pima/Santa Cruz/Yuma (including zip codes 85542, 85192, and 85550) Central GSA Maricopa/Gila/Pinal 5. Number of Successful Offerors to be awarded with each GSA: a. **Central GSA**: At least 4 Contractors awarded; b. **South GSA**: Two Contractors awarded entire GSA & at least one additional Contractor awarded for Pima County Only; *and* c. **North GSA**: Two Contractors awarded. *(AHCCCS does not intend to award contracts for all GSAs to a single Offeror. RBHAs have option to expand services to include physical health for those who choose to remain with the RBHA.)* 6. Unique RBHA Services (*no change at this time*): a. RBHA service areas do not change on 10/1/2018; b. Continue provision of behavioral health services for foster children enrolled in CMDP for physical health services; c. Continue provision of integrated physical and behavioral health for AHCCCS enrolled individuals determined to have a serious mental illness; d. Continue provision of crisis services; *and* e. Continue provision of a majority of grant funded and state-only funded services currently provided by the RBHA. Enrollment for AI Members with SMI as of 10/1 2018 - No Change: ○ AIHP/AIHP will **not** be an option ○ Enrollment options will include: ○ AIHP/TRBHA, ○ AIHP/RBHA, ○ MCO/TRBHA and ○ RBHA of both physical and behavioral health Important Facts: • American Indian members will continue to have choice and will be able to switch enrollment between integrated FFS or an Integrated Contractor at any time. • Choice options remain for American Indian members with SMI • AI members enrolled in AIHP/FFS can seek services from any AHCCCS registered provider at any time 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 any time. Services are **not limited** to providers outside of IHS/638 facilities. **Questions, Answers, Comments, Responses:** **Q:** I want to know, for people with serious mental illness (SMI), who will assist them with the process? This is extremely complicated and difficult to understand. **A1:** For those who are determined to be SMI, as defined by the State, AHCCCS has an Office of Human Rights staffed with Advocates to help people with SMI navigate the process. The Office of Human Rights is located in the Division of Health Care Advocacy and Advancement. Dana Hearn is the Assistant Director. **A2:** Yes, we agree, it is incredibly complex. So much of the work we are doing in terms of changing system design is to reduce the number of organizations involved in the payment of care. The model we used to have for individuals with SMI had to navigate four different systems that were responsible for paying for segments of their care. We believe that system design matters and the more fragmented the system, the more fragmented the care becomes in terms of delivery. We're trying to engage the community and offices at AHCCCS to work with member's families we serve. **C:** I have a recommendation and a question, 1) have AHCCCS establish a full-fledged Native American technical advisory group, 2) Is there a way to look at data composition by tribe and share with tribes? **R:** We are happy to work with the Navajo Nation on data that we are able to share. We're willing to work with tribes and share that information.
STATE PLAN AMENDMENT & TRADITIONAL HEALING SERVICES UPDATES Presenter: Kyle Sawyer, Intergovernmental Relations Specialist	**State Plan Amendment (SPA) Update:** Senate Bill 1527: As part of the 2017 Legislative session, the AZ State Legislature passed SB 1527 which added Out-Patient Occupational Therapy and Adult Emergency Dental services and Extractions up to $1000. Services for these benefits will be become effective October 1, 2017. Nursing Facility Rates: AHCCCS is updating the rates paid to nursing facilities as of July 1, 2017. The increase in rates is the result of Proposition 206 which raised the minimum wage. Disproportionate Share Hospital Program Transition: The AHCCCS Waiver requires that the Disproportionate Share Hospital (DSH) program be transitioned from the 1115 Waiver to the State Plan. The SPA makes minor changes to the methodology in order to simplify the calculation by using FFY data when available instead of prorating data over hospital fiscal years. Graduate Medical Education (GME): AHCCCS has completed the GME 2017 calculations and will be submitting 2 SPAs, 1) a placeholder SPA for 2018 once the distributions have been established for 2017 and 2) an update. The potential distribution is $295,270,475 across 21 training hospitals. Hospitals must receive a state-match portion from a local, county, tribal government or university under the AZ Board of Regents. IGA's for funding must be submitted to AHCCCS no later than August 15, 2017. AHCCCS has modified the Indirect Medical Education (IME) portion of the SPA. The AHCCCS formula replaces the Member Change Report (MCR) Full Time Enrollments (FTE) with current-year resident counts and discharges are used, rather than days, to determine Medicare utilization share. Payment of GME amounts are subject to CMS

	approval of the SPA. Further refinement of the formula is expected for the 2018 GME year. **Questions, Answers, Comments, Responses:** **Q:** What does GME mean to the tribes and tribal facilities? **A**: IHS and tribal health facilities are not currently participating in the GME program but any tribal government or facility can potentially participate. Traditional Healing Services: Kyle thanked Terry Nez and the Workgroup for the outstanding work they have done on the Traditional Healing proposal since January 2017. The Workgroup drafted the SPA which was sent to CMS. AHCCCS is awaiting CMS to give direction as to whether to continue on the SPA route go the Waiver route which was submitted previously to CMS. Once AHCCCS receives that determination we'll be able to move forward and submit the plan to cover traditional healing services. **Questions, Answers, Comments, Responses:** **Q:** Does the SPA language draft submitted to CMS classify the traditional healer as a Behavioral Health Technician and will the existing Waiver language go forward as is if CMS decides to do a Waiver? **A:** Yes, the behavioral health technician language developed by the Workgroup is the current language submitted to CMS. Regarding the Waiver route, we'll work with the base of the Waiver that was already submitted but we'll have to see what feedback CMS provides.
TRIBAL ALTCS INTERGOVERNMENTAL AGREEMENTS Presenter: Markay Adams, Assistant Director, Division of Fee for Service Management	Background: AHCCCS/DFSM has 7 IGAs with tribes, and 1 contract with Native Health that serves 14 tribes, for the delivery of Arizona Long Term Care Services (ALTCS). The IGAs were originally written and entered into in 2012. AHCCCS is updating the IGA's even though they don't expire until 2018. The reason for the update is that they were written more than 5 years ago and it would be good to reflect the government- to-government relationship and deliverables. Currently there are 2,564 members enrolled in tribal ALTCS. There are 0 members that have the Serious Mental Illness (SMI) designation and 650 members in TRBHA that have a SMI diagnosis. Through the IGA's there are additional protections through the grievance and appeals process. Updates are effective October 1, 2017. Goals: To date, DFSM has met with all tribal contractors. DFSM is partnering with tribal contractors to ensure service delivery for members with the SMI designation and update IGA's to be consistent with ALTCS EP/D RFP, AMPM Policies and AZ Rules and Statutes. Proposed Timeline: A proposed timeline of meeting dates and submission of and finalized IGA's by tribal contractors was provided. **No questions were asked**
WAIVER UPDATE Presenter: Elizabeth Lorenz, Assistant Director Office of	Institutions for Mental Diseases (IMD): The IMD waiver was submitted to CMS in April to seek exemption from a 15 day limit on services received in IMD's for adults 21-64. AHCCCS is also working with CMS on substance use disorders (SUD)in IMD's

Intergovernmental Relations	<u>New Flexibilities:</u> Letters have been written by the new Administration and sent to Governors in regard to flexibilities. Example of flexibilities include: 7. Work requirements 8. Reasonable premiums & copayments 9. Waivers of certain NEMT requirements 10. FQHC payment modernization 11. Allow more frequent eligibility re-determinations 12. Streamline Waiver and state plan process **13.** Section 1115 path to permanency. **No questions were asked**
ADJOURN	Meeting was adjourned at 12:00 p.m.