



# 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#

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### 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, 3<sup>rd</sup> 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!

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## 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, 3<sup>rd</sup> 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"> <li>• Waiver Update</li> <li>• Budget Update</li> <li>• Flexibilities Update</li> </ul>	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"> <li>• DRG Rebase</li> <li>• Personal Needs Allowance</li> <li>• IHS/638 Specialty Drug Reimbursement</li> <li>• 638 FQHC</li> </ul>	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"> <li>• Prior Quarter Coverage Proposal Change</li> </ul>	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 1<sup>st</sup> Health Plan:</u> Jearlyn Tsoisie, Scott Cummings <u>Cenpatico:</u> Sheina Yellowhair <u>Center for Medicare &amp; 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 Lebsock, 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"> <li>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.</li> </ul> <p><u>Integration Journey:</u></p> <ul style="list-style-type: none"> <li>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.</li> <li>ALTCS RFP was released on 10/16 and awarded on 3/17 and is now a fully integrated service product</li> <li>AHCCCS Complete Care RFP was released on 10/17. Award contract on 3/18 with transition to take place on 10/1/18</li> </ul> <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.

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**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.

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**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 90<sup>th</sup> 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 (DFSMS) 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 90<sup>th</sup> 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](mailto: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.*

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**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.**