





AHCCCS MCO Update Meeting

January 31, 2024

AHCCCS
Arizona Health Care Cost Containment System


Welcome/Opening Remarks

Carmen Heredia,
AHCCCS Cabinet Executive Officer and
Executive Deputy Director




Division of Grants and Innovation Update

Alisa Randall, DGI Assistant Director
Megan Woods, DGI Integrated Care Administrator

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Covered Behavioral Health Services Guide

- Ongoing work to update the new CBHSG
- Policy alignment
- Partnership with State Agencies



Fraud, Waste, Abuse Update

Alisa Randall, DGI Assistant Director
Patty Dennis, DMPS Assistant Director

AHCCCS' Response

- Collaborative response
- Temporary lodging
- Coordination with Law Enforcement
- Coordination efforts
    - Governor's office
    - ADHS
    - Attorney General's Office
    - Licensure Authority

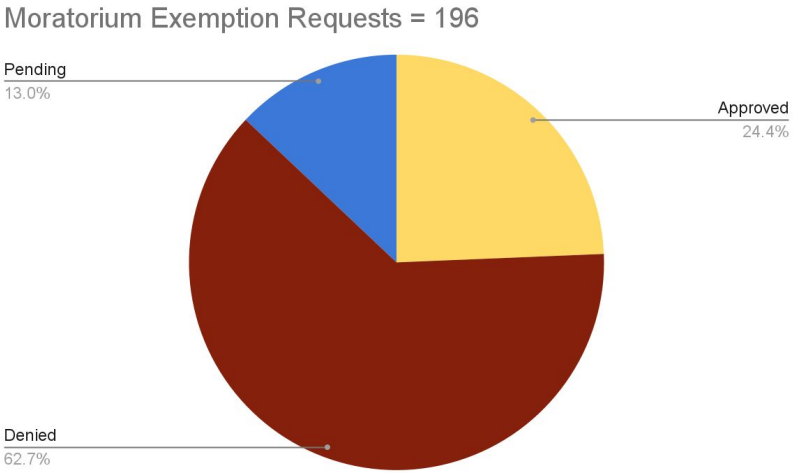
Moratorium Exemption Requests

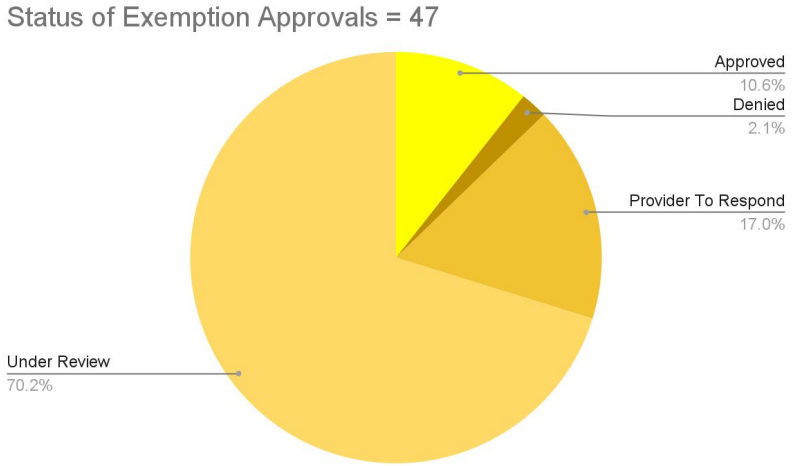
- Moratorium Extension expiration date is June 9, 2024.
- 5 Provider Types Impacted
  (Outpatient Clinic, BHRF, Integrated Clinic, NEMT and CSA).
- Moratorium Extension = Invitation to Submit Application

- MCO need for a specific Moratorium Provider email:
  Patty.Dennis@azahcccs.gov

Moratoria Data

As of 1/29/2024







Finance/Rates Update

Cynthia Layne, DBF Deputy Assistant Director
Erica Johnson, DBF Chief Actuary

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Finance/Rates

- CMS MLR Audit
- Interim Reconciliation Plan
- Rate Development/Timeline

Rates Timeline - Kickoff Reminder

Key Activity	Date
AHCCCS to Send Contractor Administrative Cost Development (ACD) Information Request	On or before 1/26/2024
Contractor ACD Information Request Responses Due	(4 weeks after sent)
Contractor Encounter Data Submission for CYE 25 Rate Setting (first cycle)	2/8/2024
Contractor Encounter Data Submission for CYE 25 Rate Setting (final cycle)	2/24/2024
Contractor Identification of Items for Consideration by Actuaries via email or meeting	February 12 through March 1, 2024
AHCCCS to Send Contractor Data Request (non-exhaustive list: member months, admin, encounters, anything noted during Contractor meetings)	On or before 3/8/2024
Contractor Data Request Responses Due	(2 weeks after sent)
AHCCCS to Send Projected Trends to Contractors	On or before 5/31/2024
Contractor Feedback to AHCCCS on Projected Trends	(2 weeks after sent)
AHCCCS to Send Projected Admin, Case Management (CM), and HCBS Mix % (if applicable) to Contractors	On or before 6/28/2024
Contractor Feedback to AHCCCS on Projected Admin, CM, and HCBS Mix % (if applicable)	(2 weeks after sent)
AHCCCS to Send Rates to Contractors with Summary of Key Items	On or before 7/12/2024
Contractor Feedback to AHCCCS on Rates	(1 week after sent)
AHCCCS to Submit Actuarial Certifications to CMS	Send on 8/15/2024

Disclaimer

Federal Relations Update

Alex Demyan, DCAIR Assistant Director
Ruben Soliz, Federal Relations Section Lead and Health Policy Advisor

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AHCCCS Federal Policy Overview

AHCCCS' Federal Relations team maintains the two federal policy documents which govern Medicaid and CHIP in Arizona:

1. **State Plan**: A 900+ page document describing various components of AHCCCS (e.g. member eligibility, available services, payment rates) permissible under federal law.
2. **1115 Waiver**: A document which grants us flexibility to design Demonstration projects that promote the objectives of the Medicaid program not otherwise authorized under federal law.

Changes to AHCCCS Federal Policy

Changes to AHCCCS Federal Policy occur through:

1. **State Plan Amendments (SPAs)**: SPAs may be used to alter the State Plan within the framework of federal law and are typically approved within 90-days.
2. **1115 Amendment Requests** may be submitted to pilot new and innovative projects. They have longer negotiation timelines and are typically approved for 5 year periods that can be renewed.

Status of Submitted 1115 Waiver Amendments

KidsCare Expansion to 225% FPL

- Submitted to CMS November 15, 2023.
- AHCCCS gathered public comments in December 2023.
- Anticipate an approval in Q1 of CY 2024.

Parents as Paid Caregivers (PPCG)

- Proposal submitted to CMS September 27, 2023.
- Negotiations underway with CMS.
- Anticipate an approval in Q1 of CY 2024

Former Foster Youth Automatic Renewal (YATI)

- Submitted to CMS March, 2023
- Currently undergoing negotiations with CMS.

Status of Submitted 1115 Waiver Amendments

Traditional Healing

- Negotiations re-initiated with CMS July 2023.
- TH workgroup helped in answering a variety of CMS questions on services, providers, eligibility, and more.
- Now awaiting additional guidance from CMS on next steps.

Pre-Release Services

- Proposal to offer a set of pre-release services to incarcerated individuals a certain number of days prior to release.
- In final stages of finalizing a concept paper detailing the updated the proposal.
- Currently evaluating the cost of the update concept paper.

Status of Other 1115 Waiver Activities

Housing and Health Opportunities (H2O)

- Implementation work has continued for targeted go live date of October 1, 2024.
- Completed information gathering phase for an RFP for H2O-PA.
- Plan to post RFP imminently.

Waiver Evaluation

- Activities underway with Independent Evaluator, HSAG.
- Evaluation Design for all Waiver Programs due to CMS on January 31, 2024.

Upcoming State Plan Amendments (SPAs)

Medicaid Children's Continuous Eligibility

- This SPA establishes 12-months of Medicaid continuous eligibility for children. It is a requirement of Section 5112 of the Consolidated Appropriations Act (2023).

CHIP Vaccine Coverage

- This SPA confirms that Arizona provides coverage and payment of vaccines recommended by the Advisory Committee on Immunization Practices (ACIP) and their administration without cost sharing to members.

Upcoming State Plan Amendments (SPAs)

Medicaid and Chip Core Set Reporting

- This SPA attests to Arizona's compliance with federal requirements for mandatory Medicaid and CHIP Core Set Reporting that were established in Final Rule 88 FR 60278.

Federal Regulatory Updates

- **Access to Care Rules**: CMS indicated that their target date for finalizing Medicaid and Managed Care Access to Care Rules is April 2024. These rules will potentially address a wide-range of issues such as member experience, reimbursement and worker compensation.

- **Nondiscrimination Rule**: HHS indicated that their target date for finalizing a Rule which implements Section 1557 of the Affordable Care Act, prohibiting discrimination in health programs, is early 2024.

Federal Regulatory Updates

- **Final Rule, Interoperability and Prior Authorization**
  - CMS finalized a Rule (CMS-0057-F) which establishes interoperability and prior authorization requirements for Medicaid FFS, Medicaid managed care plans, Medicare Advantage organizations and other entities. We will keep the community apprised of AHCCCS implications.

Public Comments

Public Comments or Written Testimony may be submitted to AHCCCS via:

Email: publicinput@azahcccs.gov

Postal Mail

AHCCCS
Attn: DCAIR
801 E. Jefferson St., MD 4200 Phoenix, AZ 85034

Opportunities for public comment are posted at the following links:

- SPAs: https://www.azahcccs.gov/AHCCCS/PublicNotices/#SPAs
- 1115 Waivers: https://www.azahcccs.gov/Resources/Federal/PendingWaivers/



COVID Unwinding Update

Patty Dennis,
DMPS Assistant Director

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COVID Unwind Update

- 98% of the 2.5million Renewals Initiated
- All 674,588 COVID Renewals Processed
    - 52% Approved
- 82% Ex Parte Auto Renewal Rate Dec 2023
- Dashboard and Heat Map

AHCCCS & Accenture Renewal Success Video

Quality Improvement Update

Georgette Chukwuemeka,
DHCS Strategic Performance Administrator

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Quality Improvement Updates: CMS

- CMS has recently issued several proposed and final rules related to Medicaid Managed Care services:
  - Final Rule: CMS-2440-F: Mandatory Medicaid and CHIP Core Set Reporting
  - Proposed Rules: CMS-2442-P: Ensuring Access to Medicaid Services; and CMS-2439-P: Medicaid CHIP Managed Care Access, Finance, and Quality
  - The proposed and final rules have substantial/potential impacts on Medicaid operations, including but not limited to standards of care, payment standards, quality measures, home and community based services, and stakeholder engagement.
- Additionally, CMS has updated State reporting requirements for other reports including reporting data at the Contractor level for the Managed Care Program Annual Report (MCPAR).

CMS: Mandatory Core Set Reporting

- CMS issued its Final Rule CMS 2440 on Mandatory Medicaid and CHIP Core Set Reporting in late August 2023, which specifies several state requirements for annual reporting on the Core Set measures.
  - On December 1, 2023, CMS issued its initial set of guidance on mandatory Core Set reporting via a State Health Official Letter (SHO 23-005).
  - Note: The FFY 2024 CMS Adult and Child Core Set technical specifications were released on January 26, 2024; additional resource manuals and technical assistance briefs are anticipated to be released by CMS in Spring 2024.

CMS: Mandatory Core Set Reporting

- Final Rule CMS-2440-F: Mandatory Medicaid and CHIP Core Set Reporting and the related State Health Official Letter outline several state requirements including, but not limited to:
  - Reporting on all measures on the 2024 Child Core Set and the behavioral health measures in the Adult Core Set by December 31, 2024
  - Reporting on all Medicaid and CHIP beneficiaries, including those enrolled in fee-for-service and managed care
  - Reporting on Medicaid beneficiaries and separate CHIP beneficiaries
  - Adhering to attribution rules for individuals who are enrolled in Medicaid and/or CHIP for the full measurement year but who move between programs or delivery systems during that time (pending CMS distribution via additional CMS resource manuals and technical assistance briefs)

CMS: Mandatory Core Set Reporting

CMS-2440-F:

- Starting with FFY 2025, states will be required to stratify a select set of mandatory measures (representing 25% of mandatory measures) by three separate categories:
  - Race and ethnicity, using the disaggregation of the 1997 Office of Management and Budget (OMB) minimum race and ethnicity categories,
  - Sex, defined as biologic sex, and
  - Geography, using a minimum standard of core-based statistical area (CBSA) with the recommendation to move towards Rural-Urban Commuting Area Codes.
- The percentage of mandatory measures for which stratification will be required will be phased in over four years, requiring 100% of mandatory measures to be stratified with the FFY 2028 Core Sets.

CMS: Mandatory Core Set Reporting

CMS-2440-F Continued:

- Mandatory measures required to be stratified, starting with FFY 2025 reporting:
  - Well-Child Visits in the First 30 Months of Life (W30-CH)
  - Child and Adolescent Well-Care Visits (WCV-CH)
  - Oral Evaluation, Dental Services (OEV-CH)
  - Follow-Up After Hospitalization for Mental Illness: Ages 6 to 17 (FUH-CH)
  - Prenatal and Postpartum Care: Up to Age 20 (PPC2-CH)
  - Live Births Weighing Less Than 2,500 Grams (LBW-CH) *CMS calculates on behalf of states*
  - Low-Risk Cesarean Delivery (LRCD-CH) *CMS calculates on behalf of states*
  - Initiation and Engagement of Substance Use Disorder Treatment (IET-AD)
  - Follow-Up After Emergency Department Visit for Substance Use: Age 18 and Older (FUA-AD)
  - Follow-Up After Hospitalization for Mental Illness: Ages 18 and older (FUH-AD)

CMS: Ensuring Access to Medicaid Services

- Proposed Rule CMS-2442-P, Ensuring Access to Medicaid Services outlines several potential state requirements including, but not limited to:
  - Requiring State Medicaid programs to have two advisory bodies: 1) The Medicaid Advisory Committee (MAC) and 2) The Beneficiary Advisory Group (BAG)
  - Requiring states to publishand regularly update Medicaid FFS payment rates for all services on a state website that is accessible and easy for the public to use
  - Strengthening person-centered service planning and incident management systems
  - Requiring that at least 80% of Medicaid payments for personal care, homemaker, and home health aide services be spent on compensation for the direct care workforce
  - Requiring states to report every other year on the HCBS Quality Measure Set for their HCBS programs

CMS: Medicaid CHIP Managed Care Access, Finance, and Quality

- Proposed Rule CMS-2439-P: Medicaid CHIP Managed Care Access, Finance, and Quality outlines several potential state requirements including, but not limited to:
  - Establishing national maximum standards for certain appointment wait times for Medicaid or CHIP managed care enrollees
  - Conducting independent secret shopper surveys of Medicaid or CHIP managed care plans
  - Conducting enrollee experience surveys in Medicaid managed care annually for each managed care plan
  - Implementing a Medicaid or CHIP quality rating system (MAC QRS), a "one-stop-shop" for enrollees to compare Medicaid or CHIP managed care plans

CMS: Medicaid CHIP Managed Care Access, Finance, and Quality

CMS-2439-P Continued:

- Increasing public engagement around state managed care quality strategies
- Submitting an annual payment analysis that compares managed care plans' payment rates for several types of services, including home and community based services
- Adhering to updated directed payment requirements
- Adhering to updated requirements on Medical Loss Ratio reporting, including requiring Medicaid managed care plans to submit actual expenditures and revenues for state directed payments as part of their medical loss ratio reports to states, and require states to submit these amounts as separate line items in their annual medical loss ratio summary reports to CMS

Contracts Update

Sandi Borys,
DHCS Contract & Policy Administrator

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Contract Timeline

New CMS Guidelines are requiring that we submit fully executed Contracts to them 90 days prior to implementation. Unfortunately, that requirement is not feasible, so we will be providing the fully executed contracts to them 45 days in advance.

In the past we submitted partially executed Contracts and submitted the fully executed signature pages 2-4 weeks after submitting the Contracts. With the new regulations we have to adjust our timelines accordingly.

CONTRACT TIMELINE										
	Initial Lock Down	Draft to MCOs	Comments Due FM MCOs	AHCCCS Responses Due	Final Lock Down	MLR, Rates, and Certs Due	Final Sent to MCOs	Signature pages due	Executed Contracts to CMS	Contract Renewal Effective
	5/16/2024	6/6/2024	6/25/2024	7/9/2024	7/12/2024	7/25/2024	7/30/2024	8/13/2024	8/15/2024	10/1/2024

Questions?

Thank You.