
August 21, 2020

Jami Snyder, Director
Arizona Health Care Cost Containment System
801 East Jefferson Street
Phoenix, AZ 85034

Dear Ms. Snyder:

In accordance with 42 CFR 438.6(c), the Centers for Medicare & Medicaid Services (CMS) has reviewed and is approving Arizona's submission of a proposal for delivery system and provider payment initiatives under Medicaid managed care plan contracts. The proposal was received by CMS on June 10, 2020, and was submitted to support the state's response to the COVID-19 public health emergency.

Specifically, the following proposal for delivery system and provider payment initiatives (i.e. state directed payment) is approved:

- Uniform increase established by the state for home and community based services including attendant care, personal care, and respite services for the rating period covering October 1, 2019 through September 30, 2020.

This approval letter does not constitute approval of any Medicaid managed care plan contracts or rate certifications for the aforementioned rating period, or any specific Medicaid financing mechanism used to support the provider payment arrangement. All other federal laws and regulations apply. This approval letter only satisfies the regulatory requirement pursuant to 42 CFR 438.6(c)(2) for written approval prior to implementation of any payment arrangement described in 42 CFR 438.6(c)(1). Approval of the corresponding Medicaid managed care plan contracts and rate certifications is still required.

Rate Certification and Managed Care Plan Contract Actions

As outlined in the [CMCS Informational Bulletin published on May 14, 2020](#), CMS will not require the state to submit a revised rate certification or rate amendment for de minimis rate adjustments resulting from state directed payments in response to COVID-19. These de minimis adjustments may increase or decrease the most recently certified actuarially sound capitation rates per rate cell up to 1.5 percent within the rating period. CMS expects states to provide: 1) documentation of how this de minimis rate adjustment ensures compliance with 42 C.F.R. § 438.7(c)(3), including the percentage change of the rate adjustment per rate cell in comparison to the most recently certified actuarially sound capitation rates and 2) an assurance that the state has not previously utilized this flexibility within the applicable rating period.

If a state directed payment impacts the capitation rates beyond the de minimis 1.5 percent per rate cell within the rating period for any rate cell, the state will need to submit a revised rate certification or rate amendment to address and account for all differences from the most recently certified rates. Documentation expectations are outlined further in the [Medicaid Managed Care Rate Development Guide](#).

The state is always required to submit a contract action(s) to incorporate the contractual obligation for the state directed payment and related capitation rates that include this payment arrangement.

Risk Mitigation

As a condition of approval of this proposal, the state is required to implement two-sided risk mitigation as noted in the [CMCS Informational Bulletin published on May 14, 2020](#). If the state does not currently have two-sided risk mitigation in place or is seeking to make an existing risk mitigation arrangement comply with these requirements, the state must submit both a contract amendment and a revised actuarial rate certification to effectuate these changes. States should follow the guidance in the [Medicaid Managed Care Rate Development Guide](#) for documentation of risk-sharing mechanisms.

Monitoring and Evaluation

CMS understands that the state is requiring their managed care plans to implement this payment arrangement to address access concerns in light of the COVID-19 public health emergency. If the state requires their managed care plans to implement this payment arrangement in future rating periods, the state will need to provide the following additional information as part of future preprint submissions:

1. A more detailed evaluation plan for determining if this payment arrangement furthers the goal and/or objective identified by the state in its Quality Strategy. This more detailed evaluation plan must include:
 - a. Identification of a specific measure(s) that will be used in this evaluation;
 - b. The baseline year of the data that will be used;
 - c. The target that the state is setting for the identified measure(s) to determine if this payment arrangement has been effective in furthering the identified goal and/or objective in the Quality Strategy; and
 - d. The party that will be conducting the evaluation (e.g. EQRO or state staff).
2. An analysis of the impact this payment arrangement will have on the reimbursement level for the identified provider class to demonstrate that this payment arrangement is reasonable, appropriate and attainable. This analysis should provide an estimate of the average base amount the managed care plan(s) pay and then the effect of this payment arrangement on total reimbursement for the identified provider class as a percent of Medicare or other appropriate standardized measure (e.g. Medicaid fee-for-service rates).

If you have questions concerning this approval or state directed payments in general, please contact Alex Loizias, Division of Managed Care Policy, 410-786-2435 and alexandra.loizias@cms.hhs.gov.

Sincerely,

John Giles, MPA
Director, Division of Managed Care Policy
Center for Medicaid and CHIP Services