State Medicaid Advisory Committee (SMAC)

Tuesday, January 20, 2015
AHCCCS
Gold Room - 3rd Floor
701 E. Jefferson Street
10 a.m. – 12 p.m.

Agenda	
I. Welcome	Director Thomas Betlach
II. Introductions of Members	ALL
III. Approval of October 22, 2014 meeting summary	ALL
Agency Updates	
IV. AHCCCS Update • Budget, Enrollment and Litigation, Greater AZ, SIM Grant, Updated Org Chart	Director Thomas Betlach
V. CMS Update • Waiver Approval Package and Updates	Theresa Gonzales Office of Intergovernmental Relations
VI. Reports	Amy Upston Hospital Finance Administrator
VII. Other State Initiatives	Mohamed Arif Management Intern
VIII. Membership • Bylaws and Federal Regulations	ALL
Discussion	
IX. Call to the Public	Director Thomas Betlach
X. Adjourn at 12:00 p.m.	ALL

2015 SMAC Meetings

Per SMAC Bylaws, meetings are to be held the 2nd Wednesday of January, April, July and October. All meetings will be held from 1 p.m.- 3 p.m. unless otherwise announced at the AHCCCS Administration 701 E. Jefferson, Phoenix, AZ 85034, 3rd Floor in the Gold Room:

January 20, 2015
April 8, 2015
July 8, 2015
October 7, 2015

For more information or assistance, please contact Theresa Gonzales at (602) 417-4732 or theresa.gonzales@azahcccs.gov

October 2014 Meeting Summary

State Medicaid Advisory Committee (SMAC) Meeting Summary Wednesday, October 22, 2014, AHCCCS, 701 E. Jefferson, Gold Room 9:00 a.m. – 11:00 a.m.	
Members in attendance: Tom Betlach Sheila Sjolander on behalf of Will Humble Kathy Waite Tara McCollum Plese Kevin Earle Phil Pangrazio Tomas Leon	Amanda Aguirre by phone Kathleen Collins Pagels Leonard Kirschner by phone Kathy Byrne by phone Kim VanPelt by phone Peggy Stemmler Steve Jennings
Members Absent: Vernice Sampson	
Staff and public in attendance: Theresa Gonzales, Exe Const. III, AHCCCS Marcus Wilson, Policy & Planning, DES Christopher Deere, Policy & Planning, DES Kim Maslonka, Administrator, Mercy Maricopa Suzanne Legander, CEO, S.T.A.R. Michelle Pabis, Director, SHC Arnaldo Maldonado, COO, Hope Lies	Bonnie Talakte, Tribal Liaison, AHCCCS Terry Magden, Sr. P.M., AHCCCS Markay Adams, BH Coordinator, AHCCCS Christopher Vinyard, Legislative Liaison, AHCCCS Cathy Geiger, Nurse Case Mgr., AHCCCS Jamaal Mathews, Care Coordination, AHCCCS Lynne Bergeson, Nurse Case Mgr., AHCCCS Shannon Groppenbacher, Director Health Policy, JNT

AGENDA

I. Welcome & Introductions — **Tom Betlach**

II. Introductions of Members — **All**

III. Approval of July 9, 2014 Meeting Summary/Minutes — **Unanimous**

AGENCY UPDATES

IV. AHCCCS Updates — **Tom Betlach**

- Hospital Assessment & Litigation
- Medicaid Restoration
- AHCCCS Enrollment Growth
- Prop 204 Adult Restoration
- AHCCCS Adult Expansion
- Total AHCCCS Acute
- Hospital Assessment Funding Levels
- Medicaid/CHIP Enrollment Millions of Enrollments per month

AHCCCS Updates (continued)

- Eligibility Update
  - **AHCCCS Update Q&A's**
    - Q: Will the denial letters sent out by Health-e-AZ be resolved by Nov. 15th?
    - A: There will be language in the denial letter stating that their application will be sent to HEAplus.
  - **Comments:**
    - Challenges for DES
    - KidsCare #s to the Market Place.
    - Are employers sending employees to the Marketplace

- AHCCCS/DES Call Volume
- Safety Net Care Pool
- AHCCCS Funding by Source
- Budget Update
- Budget Reduction Options
- Provider Rate Changes (2009-15)
- Average Annual Capitation Growth
- AHCCCS Spending 2001-2015
- General Fund for AHCCCS Programs
- Distribution of Average Income Growth During Expansions
- Sovaldi
- Improving Federal Estimates
- Payment Modernization
- Program Integrity Avoidance and Recovery Savings
- Fragmentation Initiatives
- Grater AZ RBHA
- Aligned Dual Members
- American Indian Health Plan
- Justice Transition Initiatives
- Other Issues
  - **Q&A's**
    - Q: Does AHCCCS keep a provider directory?
    - A: Health Plans keep current providers enrolled per contracts
  - **Comments:**
    - Market Place
      - Debate for network structure
      - Cost vs. Choices
      - Price Issues
      - Timely Claims
      - Requirements; all different structures vary
      - Factoring in the analysis on structures
      - Draft rules coming out in 2015
    - For Transparency; Consumer Information - Health Plan Report Cards.
    - Health Plan Report Card; some more feedback.

- Arizona SIM Vision
- SIM Strategies

V. CMS Update **Theresa Gonzales**

- AZ Medicaid State Plan Amendments
- Pregnant Women and Hospital Presumptive Eligibility (HPE)
- SNCP and I.H.S./638 Extension Waiver Amendment Requests
- Tuba City Regional Health Care Corporation
- Behavioral Health Integration

  Comments:
  - HCBS new regulations; AHCCCS is reviewing and will be collecting public comments and start a transition plan.
  - No Federal oversight on assisted living.
  - ALTCS; dealing with a lot of uncertainty.
  - Consumer protections
  - Star Rates
  - Dual Eligible Models
  - Draft regulations by 10/1/2016

VI. Membership **Theresa Gonzales**

- Term – Affirmation Statement
- SMAC Nomination Form
- Bylaws and Federal Regulations
  - Changing the Bylaws
  - Additional 2 members to the SMAC committee

  Comments:
  - Compensate for travel, time or child expense.
    - Pediatrics – Worked with individuals for the broader community.
  - How will they understand that information and will it be meaningful?
  - Excellent idea to add members; NAMI reaching out to the community.
  - Provide an AHCCCS 101 Orientation to new members
  - Have a mentor with a longer standing member of the SMAC committee.
  - One from the Tribal community.

DISCUSSION

VII. Call to the Public **Tom Betlach**

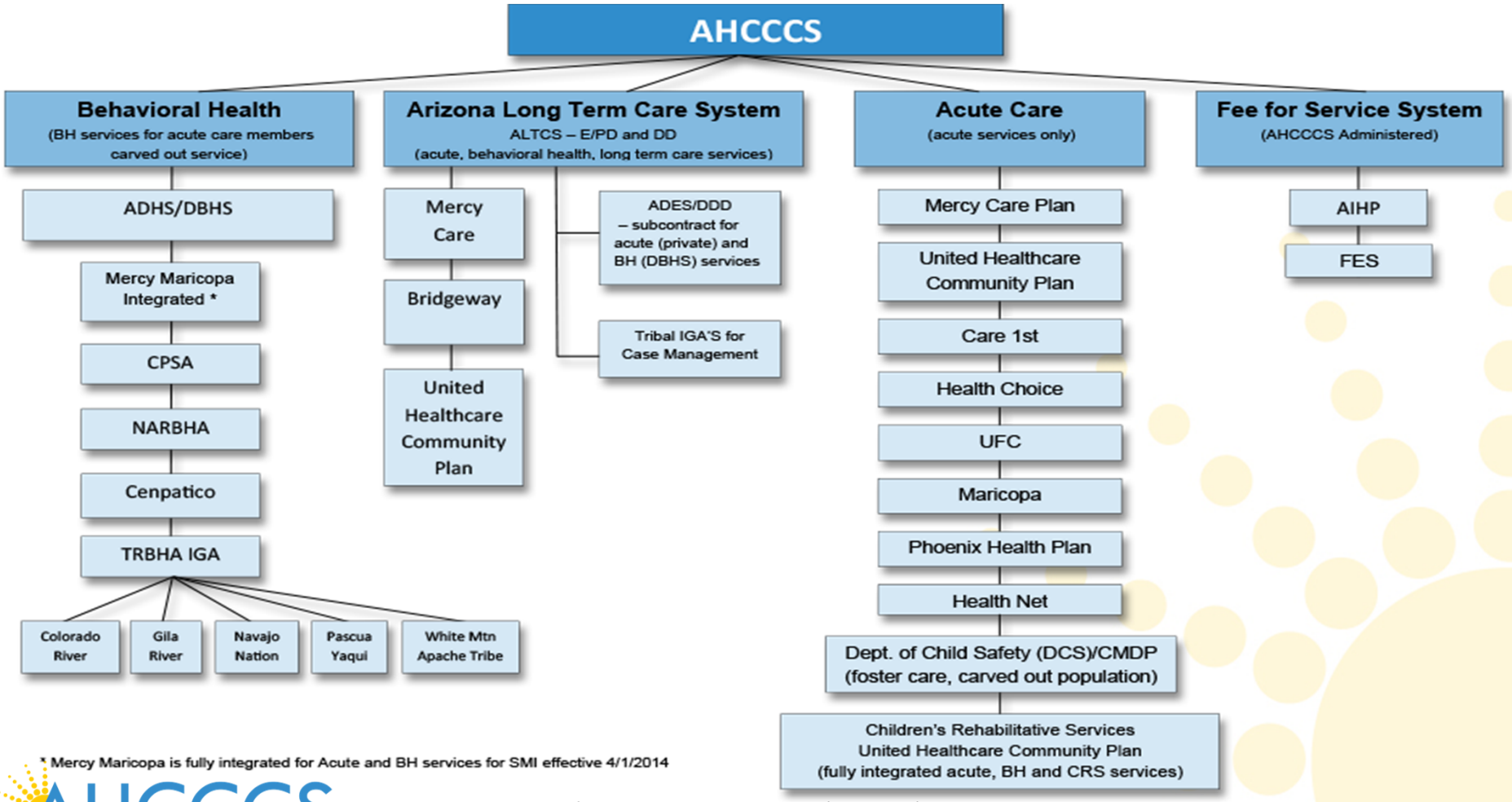
- **Suzanne Legander**
  - **S.T.A.R. Handout**
- Central Arizona Dental Society hosting AZ Mission of Mercy (MOM) on December 12 & 13, 2014.

VIII. Adjourn at 11:00 p.m. **All**

AHCCCS Update

AHCCCS Update

AHCCCS Care Delivery System

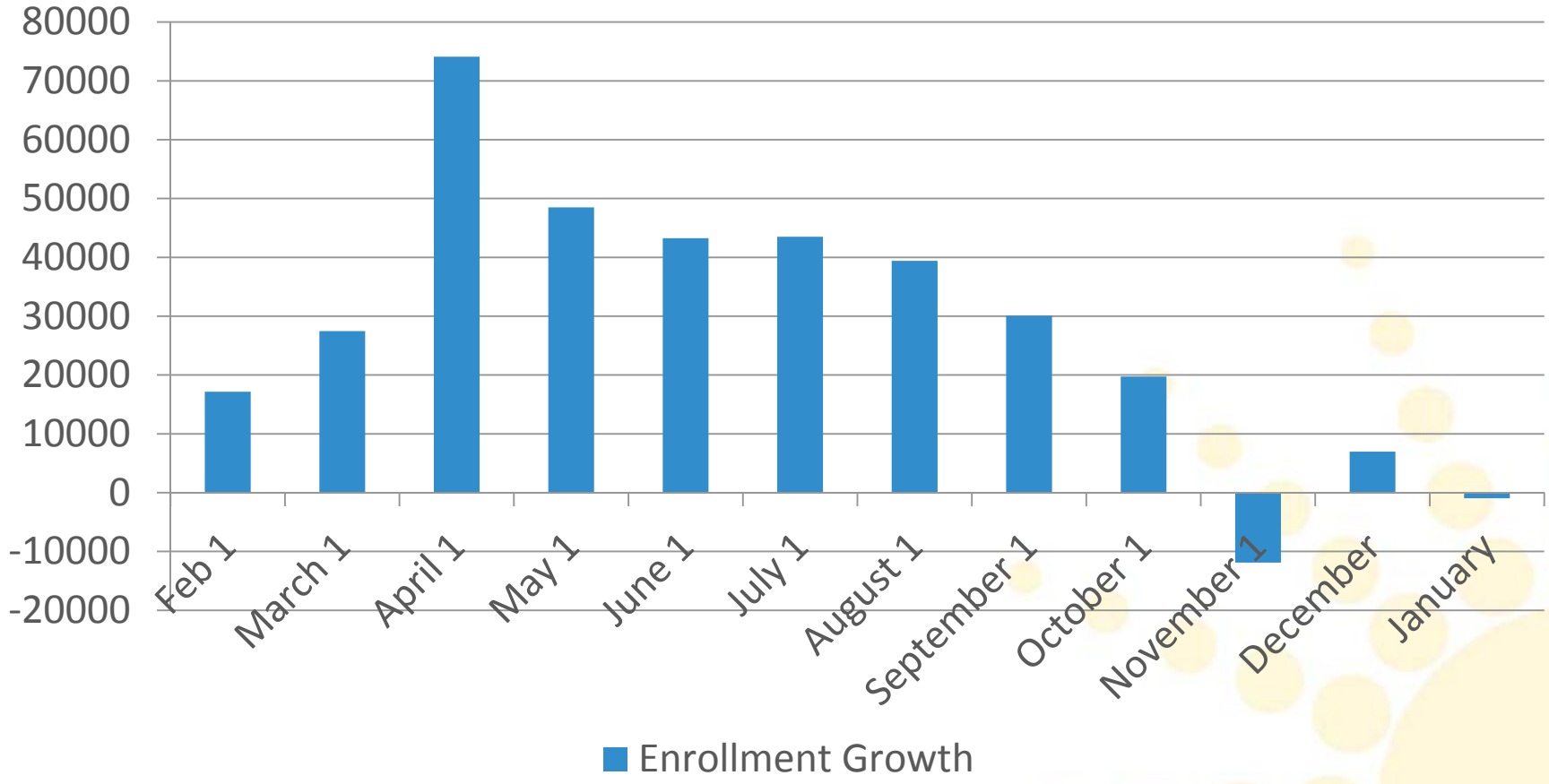


* Mercy Maricopa is fully integrated for Acute and BH services for SMI effective 4/1/2014

Medicaid Restoration

	12/1/2013	1/1/2015	Change
Prop 204 Restoration	67,770	279,097	211,327
Adult Expansion	0	36,373	36,373
KidsCare	46,761	1,872	-44,889
Family Planning	5,105	0	-5,105
AHCCCS for Families & Children (1931)	672,135	699,674	27,539
All Other	505,379	618,523	113,144
Total Enrollment	1,297,150	1,635,539	338,389

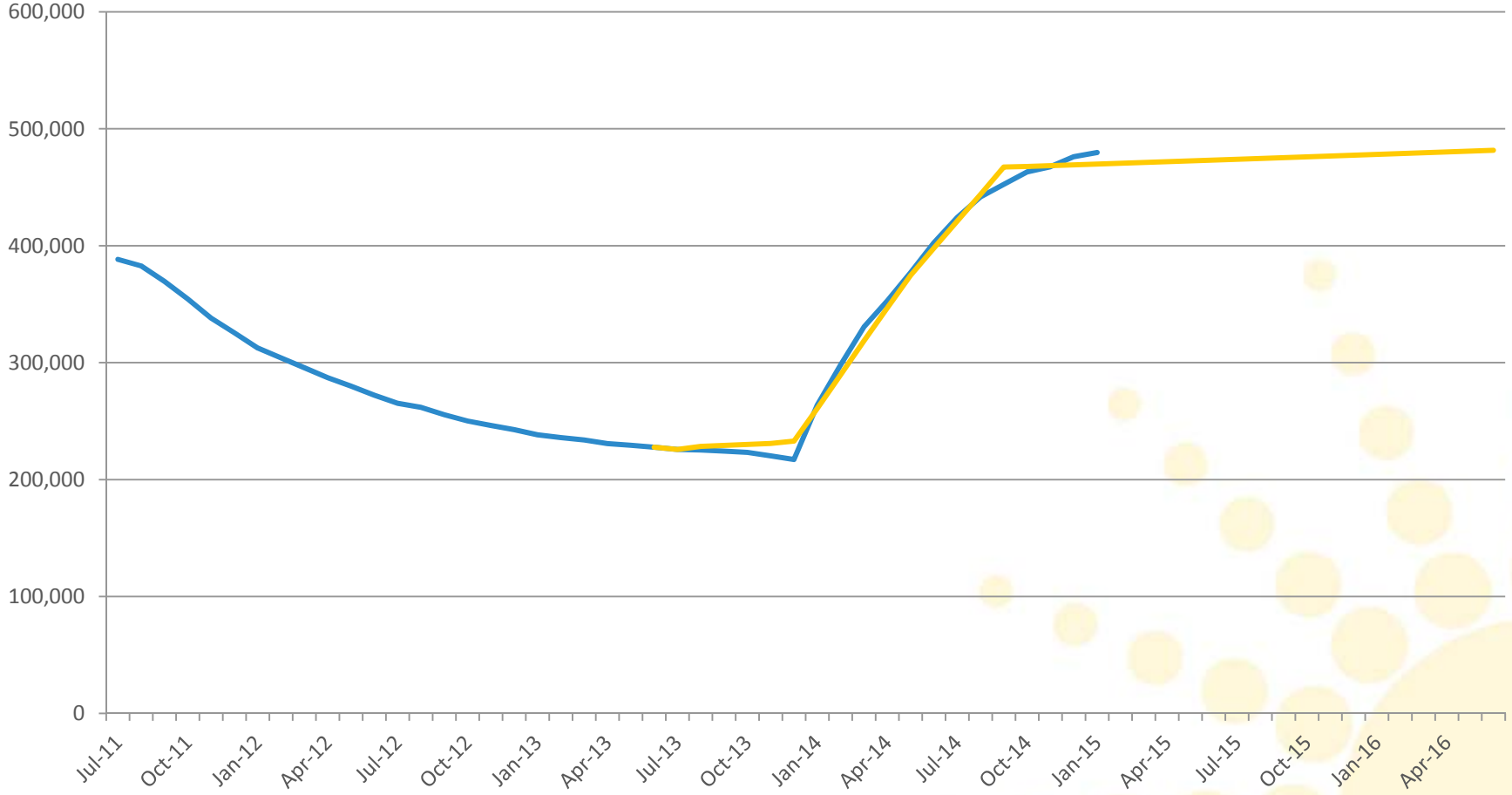
AHCCCS Enrollment Growth



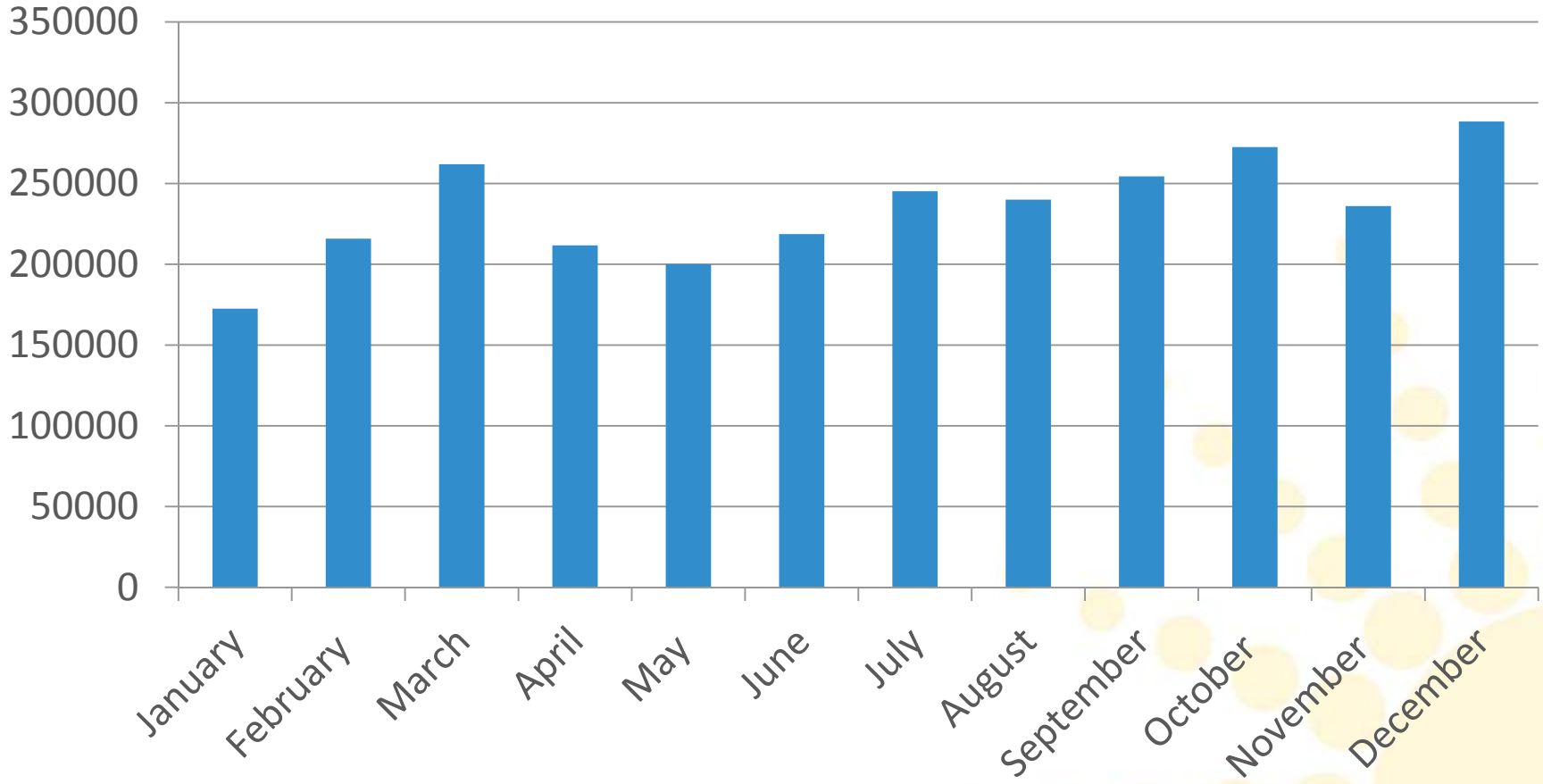
AHCCCS
Arizona Health Care Cost Containment System

Reaching across Arizona to provide comprehensive quality health care for those in need

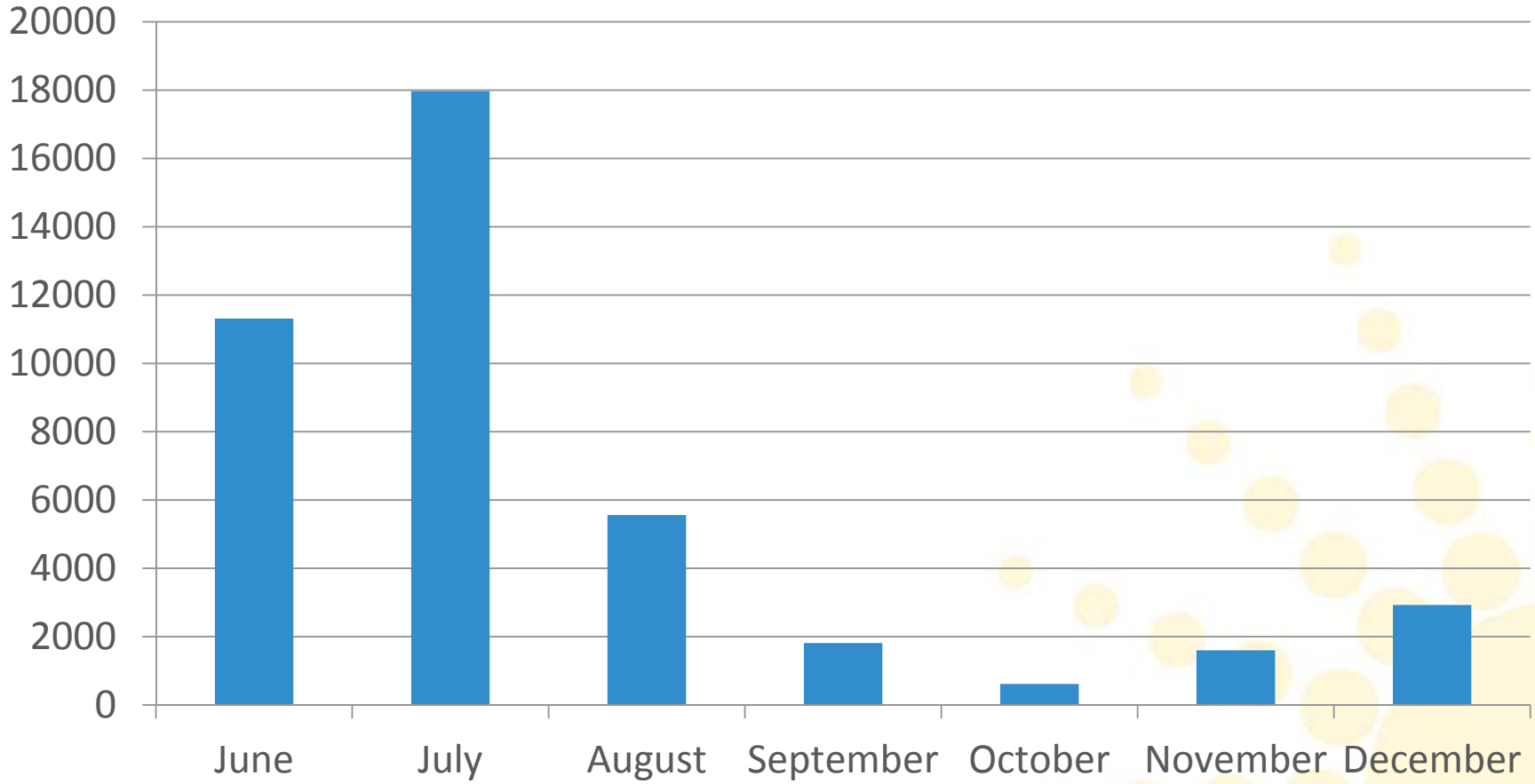
Restoration/Expansion Actual to 2013 Estimates



AHCCCS/DES Call Volume



Total FFM Approvals for AHCCCS



AHCCCS
Arizona Health Care Cost Containment System

Reaching across Arizona to provide comprehensive quality health care for those in need

FY 15 & FY 16 Executive Budget

- How big is the problem?
  - FY 15 - $160 m
  - FY 16 - $533.7 m
- AHCCCS Recommendation
  - 3% Provider Rate Reduction – in FY 15
  - DD Provider rates exempt
  - Flexibility for AHCCCS in analysis
  - DSH Changes
  - Some funding included for ALTCS Dental

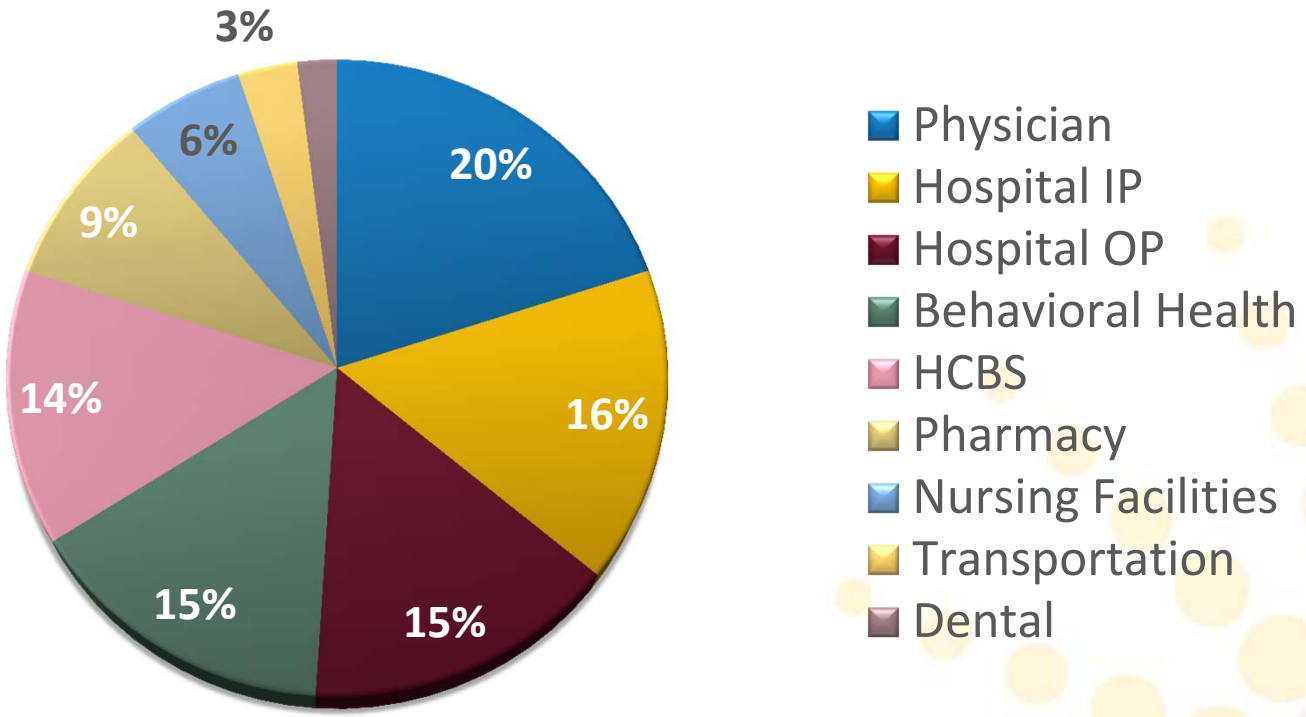
AHCCCS Budget Rec

- Governor's Initiative for Administrative Simplification with BHS and AHCCCS fully effective July 1, 2016
- Current Structure is redundant – AHCCCS oversees BHS
- No services are cut and no change in how services are delivered
- All existing contracts (and new awards) remain in place – moves existing RBHA contracts to AHCCCS for oversight
- This transition will be seamless to those who need services and the family members that support them
- We will be thoughtful in transition and work to bring the best of both organizations together
- We will be reaching out to stakeholders for input as part of transparent process

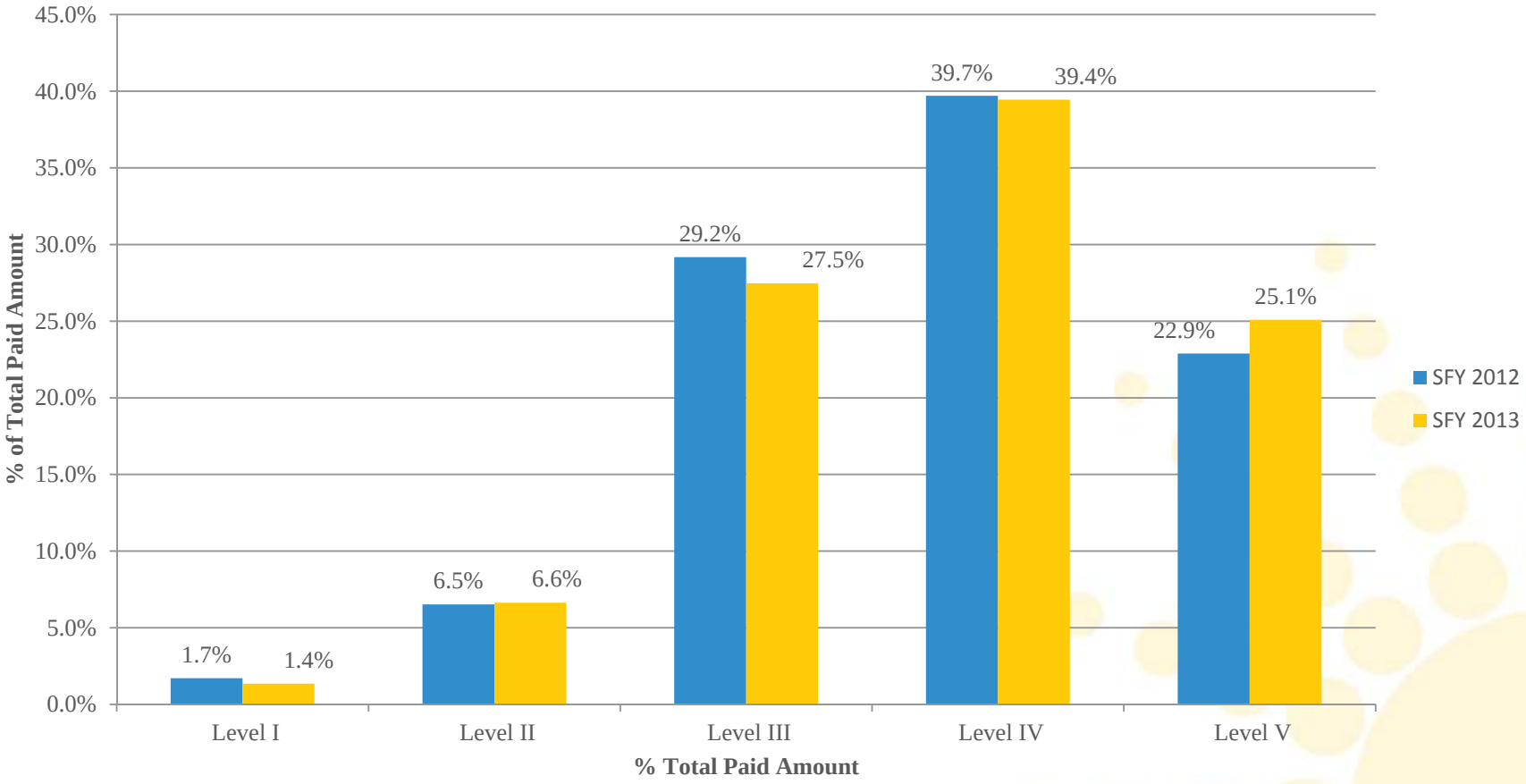
Impact of Enhanced Match (Millions)

Funding Source for Adults 0-100%	FY 16 Current Law – 90% match	FY 16 – Traditional Match
Tobacco Funds	156.4	156.4
Hospital Assessment	245.9	0.0
General Fund	114.3	746.8
Federal Funds	2,630.6	2,244.1
Total Funds	3,147.3	3,147.3

Spending by Provider Type



ED Utilization: % of Total Paid Amount



AHCCCS
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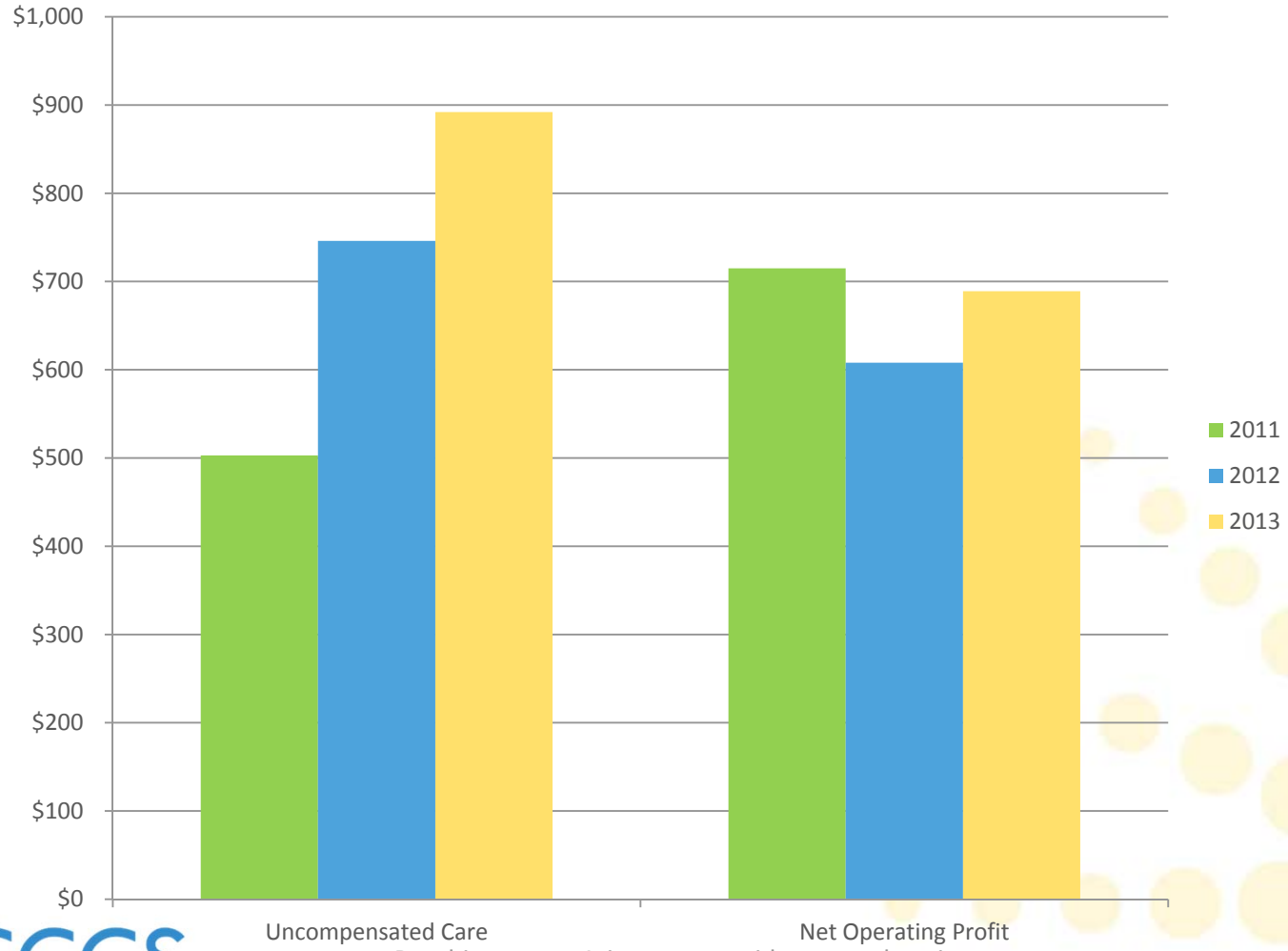
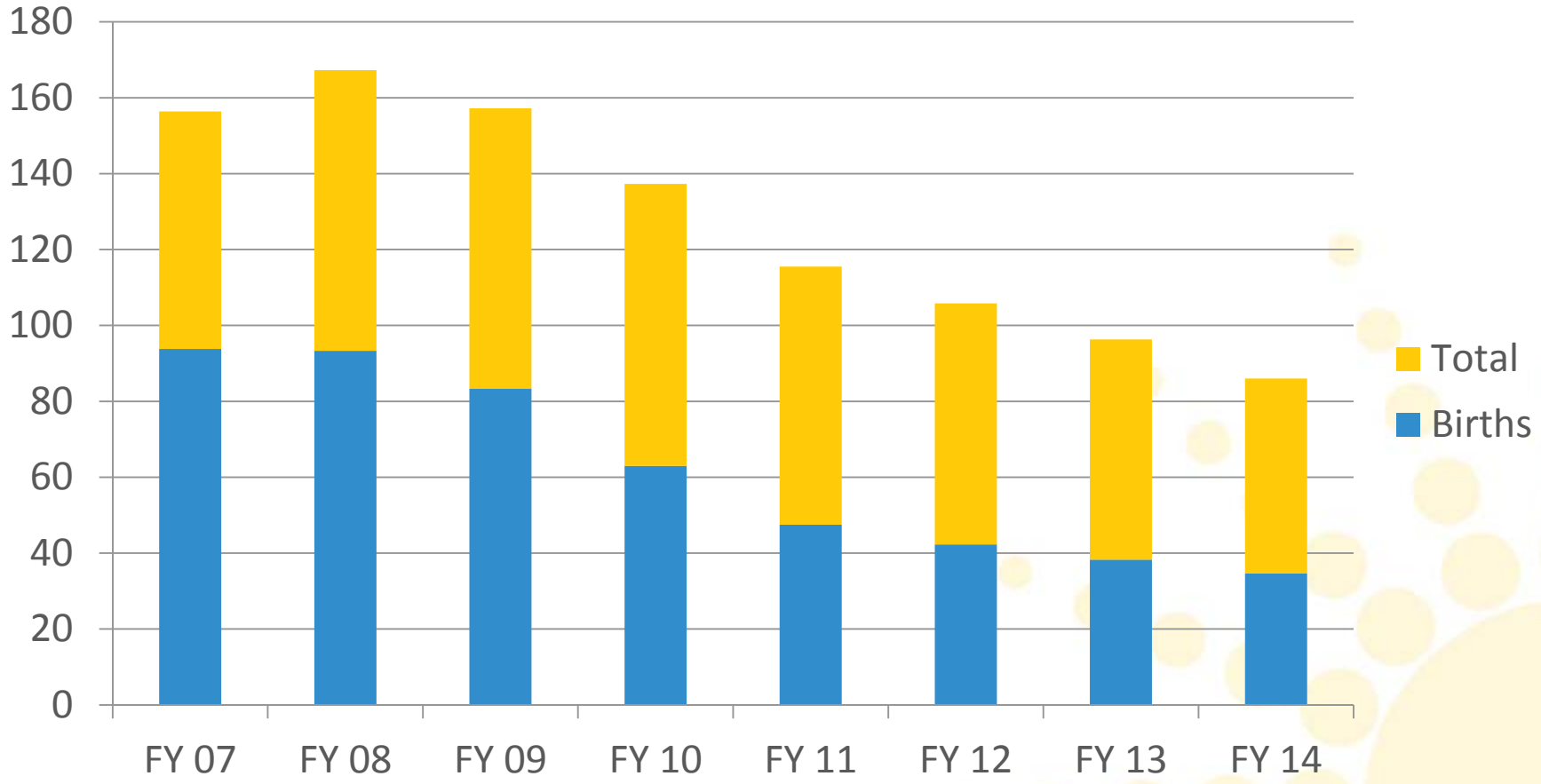
Reaching across Arizona to provide comprehensive quality health care for those in need

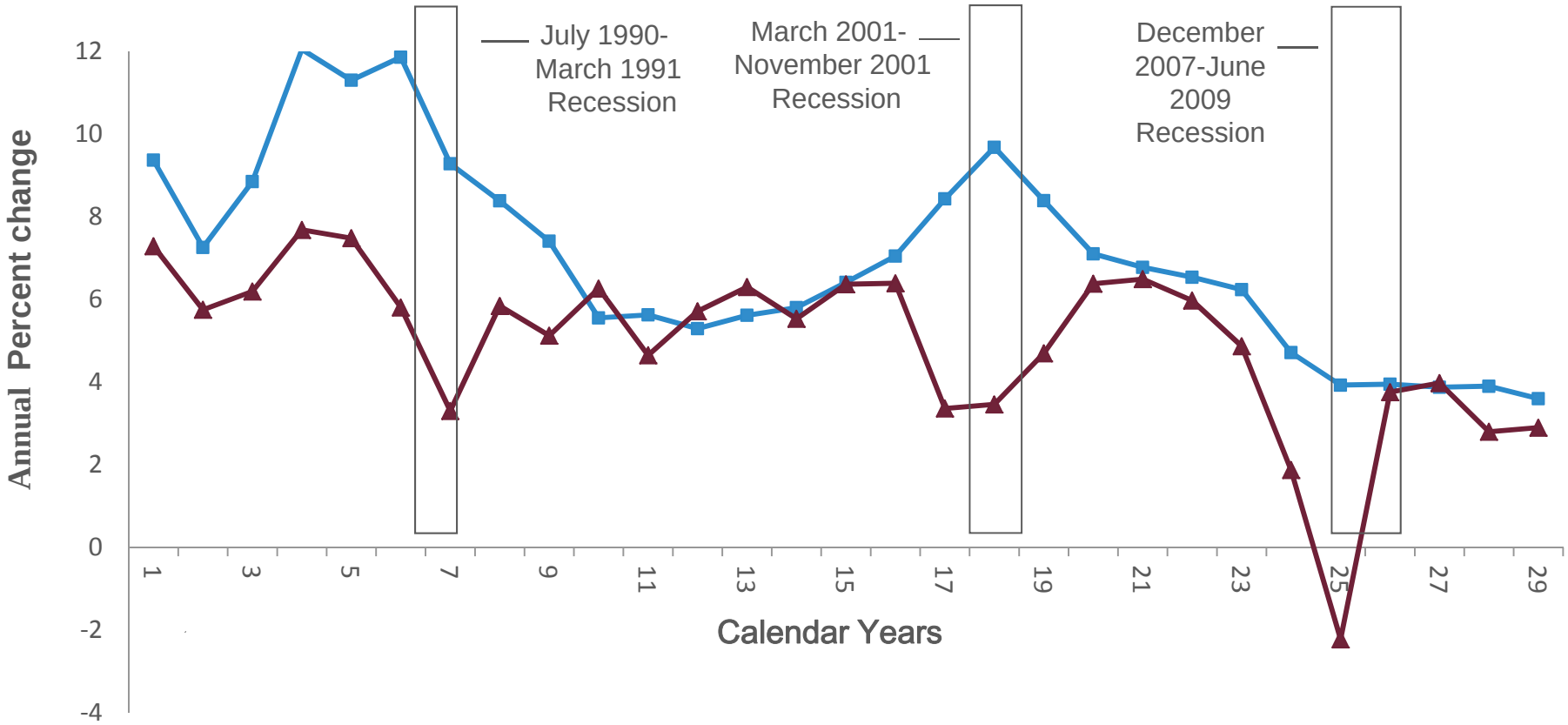
Hospital Uncompensated Care and Net Operating Profits, 2011-2013 ($ in millions)



Federal Emergency Expenses

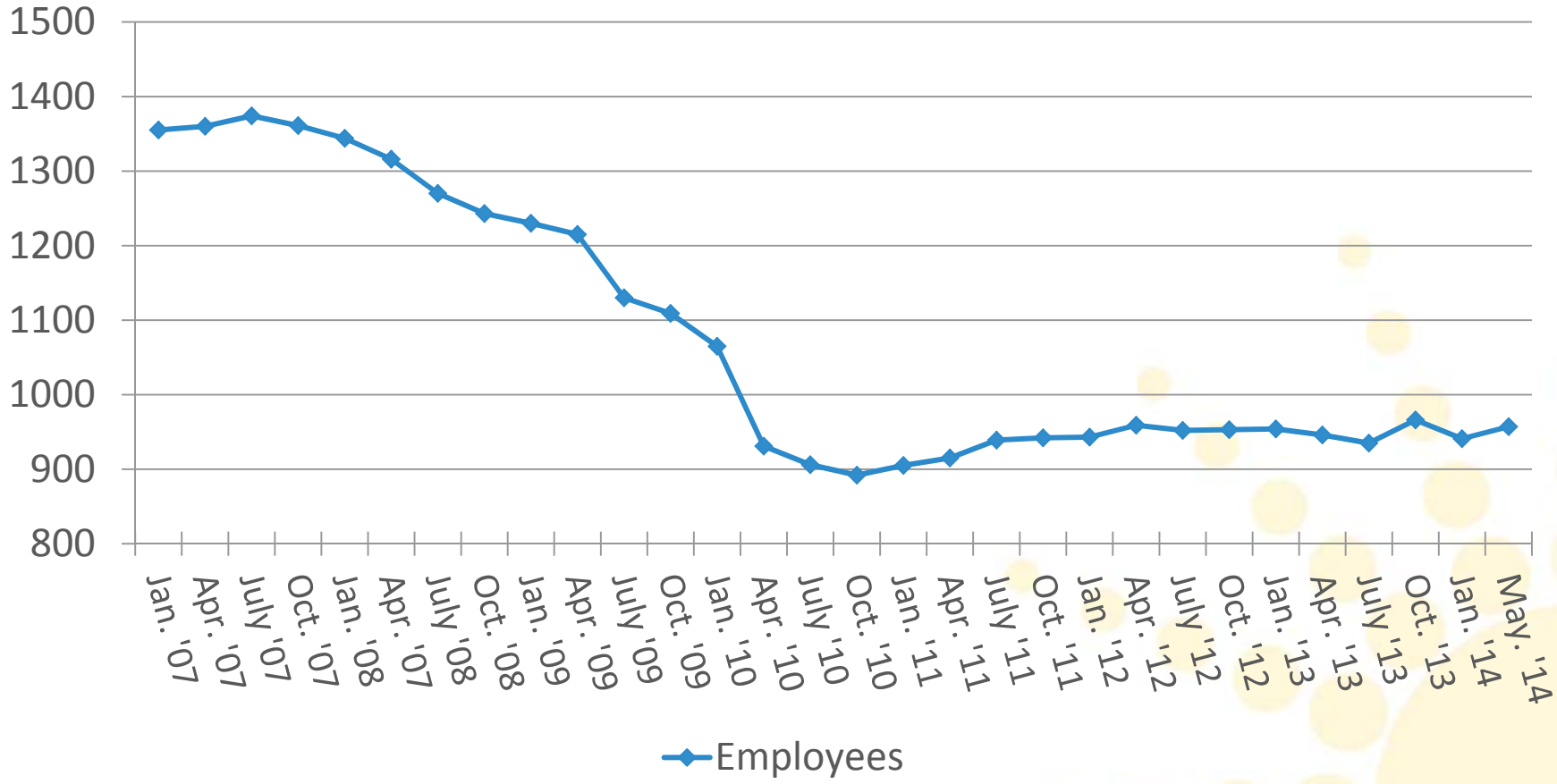


Growth in National Health Expenditures and Gross Domestic Product (GDP), 1985-2013

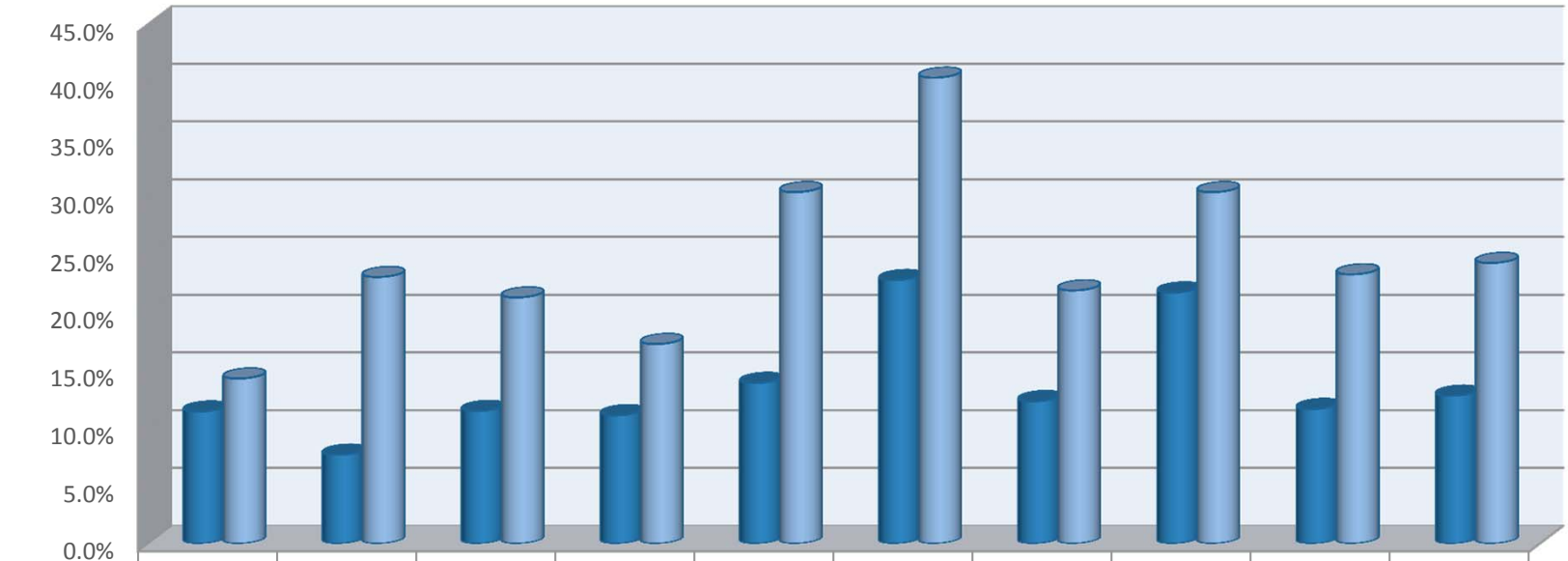


SOURCE: Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Statistics Group, U.S Department of Commerce, Bureau of Economic Analysis and National Bureau of Economic Research, Inc.

AHCCCS Staffing Levels



Potential Retirees



	OOD	HRD	OIG	DHCM	ISD	DBF	DFSM	OALS	DMS	AGENCY TOTAL
CYE 2015	11.4%	7.7%	11.5%	11.1%	13.9%	22.8%	12.3%	21.7%	11.7%	12.8%
CYE 2018	14.3%	23.1%	21.3%	17.3%	30.4%	40.4%	21.9%	30.4%	23.3%	24.3%

Delivery System Transformation Initiatives

1. Members with Serious Mental Illness
2. High Need High Cost - Super Utilizers
3. Dual Eligible Members
4. American Indian Health Program
5. Justice System Transitions
6. Health Information Technology
7. Blind Spot Data Sharing
8. Children with Special Needs

Other Items

- Hospital Assessment
- Greater AZ RBHA
- PCP Rate Bump – expiration 12-31-14
- SIM Update - $2.5 m Design
- Marketplace Changes – UAHN/Banner – Care 1st/California Blue Shield
- CMS Staffing Changes

AHCCCS Procurements

- 10-1-15 Greater AZ RBHA Transition
- 10-1-16 DD Acute Contracts
- 10-1-17 ALTCS Contracts
- 10-1-18 Acute Care
- 10-1- ? RBHA

CMS Update

CMS Update

State Plan Activity

The State Plan is a comprehensive written contract between AHCCCS and the Centers for Medicare and Medicaid Services (CMS) that describes the nature and scope of Arizona's Medicaid program and assures that Arizona will administer its programs according to federal requirements under the provisions of the Social Security Act (SSA). The State Plan also provides a basis for Federal Financial Participation (FFP).

AHCCCS submits State Plan Amendments (SPAs) for CMS approval to reflect changes in federal and state laws, regulations, policy, or court decisions. The following is a summary of Arizona's SPA activity over the past 3 years:

2014: 17 SPAs submitted; 9 approved; 8 pending
2013: 19 SPAs submitted; 19 approved; 0 pending;
2012: 15 SPAs submitted; 12 approved; 1 pending; 2 withdrawn
2011: 25 SPAs submitted; 24 approved; 0 pending; 1 withdrawn
2010: 17 SPAs submitted; 16 approved; 1 withdrawn
2009: 6 SPAs submitted; 5 approved; 1 denied

More information can be found at:
http://www.azahcccs.gov/reporting/PoliciesPlans/StatePlanAmendments.aspx

Waiver Activity

The 1115 Waiver refers to section 1115 of the Social Security Act. AHCCCS has been exempt from specific provisions of the SSA, under an 1115 Waiver since Arizona first began participating in Medicaid on October 1, 1982. Arizona's 1115 Waiver includes provisions in the SSA and corresponding regulations AHCCCS is exempt from; terms and conditions that AHCCCS must fulfill; approved federal budget amounts. AHCCCS submits waiver amendments to reflect changes in federal and state laws, regulations, policy, and court decisions. The following is a summary of Arizona's Waiver activity:

On December 15, 2014, CMS approved Arizona's 1115 Waiver amendment request that will:

1. Expand integration of physical and behavioral health services for adults with serious mental illness throughout the State;
2. Extend the Safety Net Care Pool for the Phoenix Children's Hospital;
3. Extend uncompensated care payments to Indian Health Services and 638 Tribal facilities; and
4. Cover all Medicaid services for pregnant women during their hospital presumptive eligibility period.

AHCCCS continues to work with CMS on its request to use federal matching funds for services provided by Tuba City Regional Health Care for inmates of the Navajo Detention Center and to charge premiums to individuals with income above 100% FPL. CMS did not approve Arizona's request to require $200 co-pays for non-emergency use of the emergency room for individuals with income above 100% FPL.

More information about waivers can be found at:
http://www.azahcccs.gov/reporting/federal/waiver.aspx

2014 Amendments

SPA 14-014 – ABP Cost-Sharing
Updates the State Plan to include cost-sharing for individuals with income over 100% FPL.

Submitted 12/3/14 [PDF]

SPA 14-013-D – Nursing Facility Rates
Updates reimbursement rates for Nursing Facilities for the period October 1, 2014 to September 30, 2015.

Submitted 10/31/14 [PDF]

SPA 14-013-C – Other Provider Rates
Updates reimbursement rates for other providers for the period October 1, 2014 to September 30, 2015.

Submitted 10/31/14 [PDF]

SPA 14-013-B – Outpatient Rates
Continues current outpatient hospital reimbursement rates for the period October 1, 2014 to September 30, 2015.

Submitted 10/31/14 [PDF]

SPA 14-013-A – Freestanding Psychiatric Hospital Rates
Continues rates for freestanding psychiatric hospitals for the period October 1, 2014 to September 30, 2015.

Submitted 10/31/14 [PDF]

SPA 14-012 - GME
Updates GME funding for the service period July 1, 2014 through June 30, 2015 for programs with submitted IGAs.
Submitted 9/30/14 [PDF]

SPA 14-011 - Third Party Liability
Updates the State Plan to reflect changes to Third Party Liability.
Submitted 9/30/14
Approved 12/2/14

SPA 14-010 – Insulin Pumps
Updates the ABP and State Plan to include insulin pumps as a covered benefit.
Submitted 9/9/14
Approved 12/2/14

SPA 14-009 – ARP-DRG
Describes the All Patient Refined Diagnosis Relation Group hospital reimbursement methodology in the State Plan for Inpatient dates of service on and after October 1, 2014.
Submitted 8/27/14
Approved 10/21/14

SPA 14-008 – Presumptive Eligibility
Describes Presumptive Eligibility by Hospitals in Arizona.
Submitted 3/28/14
Presumptive Eligibility in Arizona

SPA 14-004 – Therapies
Revises the State Plan to reflect updates to therapies covered under the State Plan.
Submitted 2/20/14
Approval 12/16/14

SPA 14-001 – ADHS Licensure Changes
Revises the State Plan to reflect updates to the licensing of health programs.
Submitted 1/10/14

Reports

Hospital Reports Recently Submitted to the State Legislature

January 20, 2015

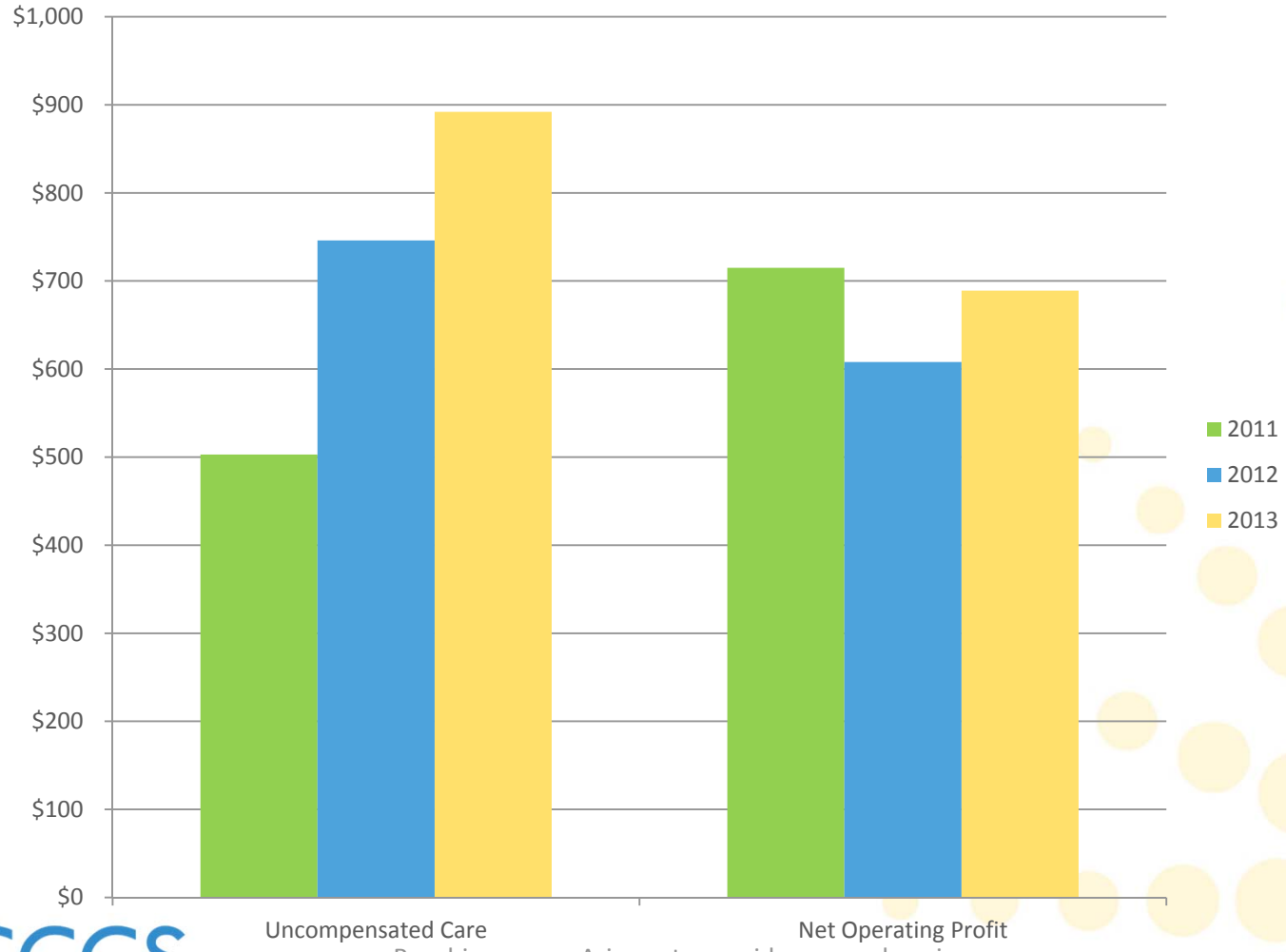
AHCCCS
Arizona Health Care Cost Containment System

Reaching across Arizona to provide comprehensive quality health care for those in need

Uncompensated Hospital Costs & Profitability Report

- Statutorily required report on change in uncompensated hospital costs experienced by Arizona hospitals and hospital profitability during the previous fiscal year
- Due October 1
- Included hospital specific data
- Working with others in AHCCCS to create web pages which will show much of the same hospital specific information as included in report
  - Should be available in January

Hospital Uncompensated Care and Net Operating Profits, 2011-2013 ($ in millions)



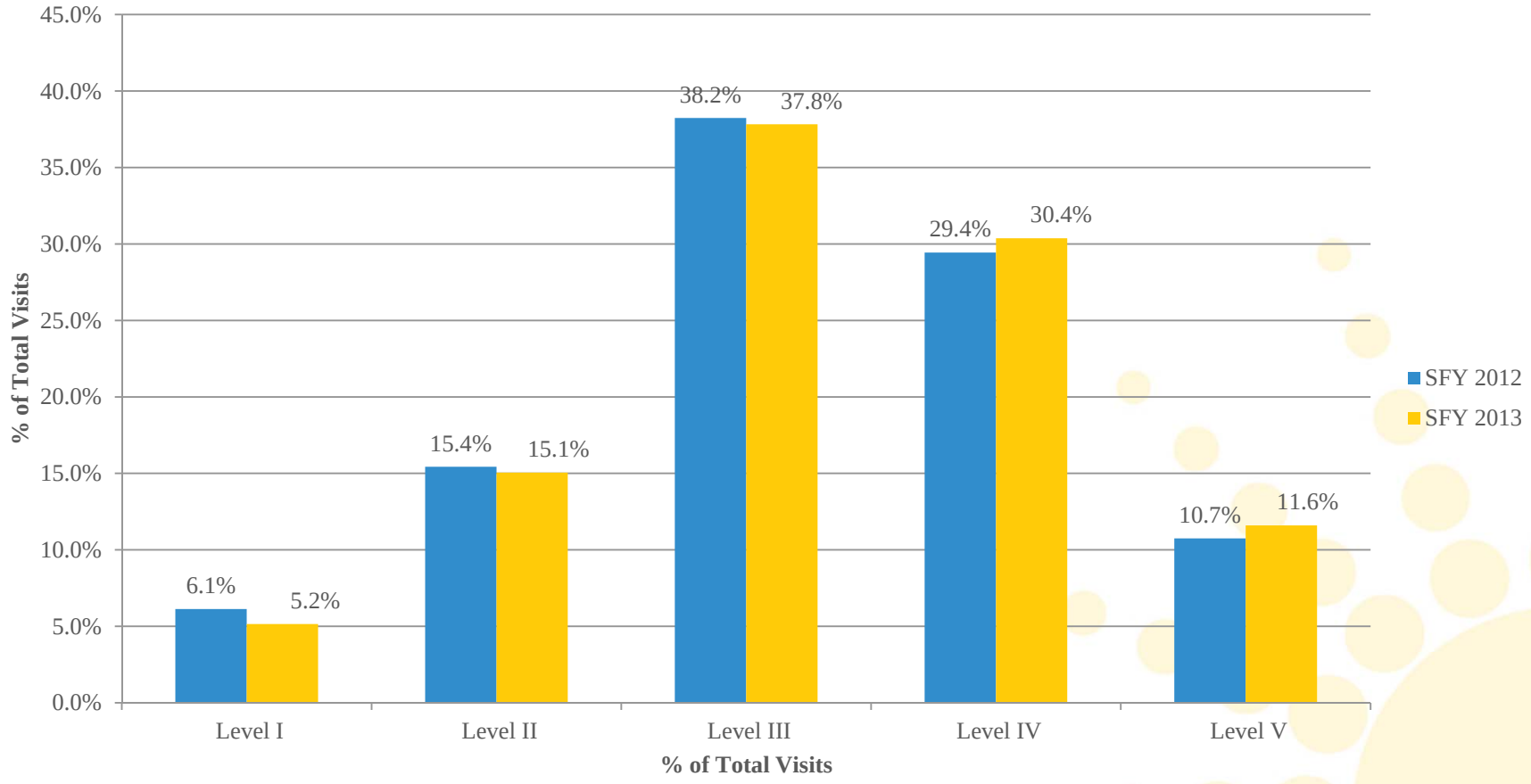
Uncompensated Hospital Costs & Profitability Report (con't)

- Much of the profitability increase appears to be related to SNCP, since SNCP payments increased from $185 million in HFY 2012 to $510 million in HFY 2013
- Stratified data by for profit vs. non-profit hospitals, urban vs. rural hospitals, hospital peer types, and hospital systems
- A number of changes have occurred since HFY 2013
  - Implementation of the Governor's Medicaid plan
  - Reduction in payments when readmissions occur
  - Continued movement towards outpatient services
  - Several hospital purchases

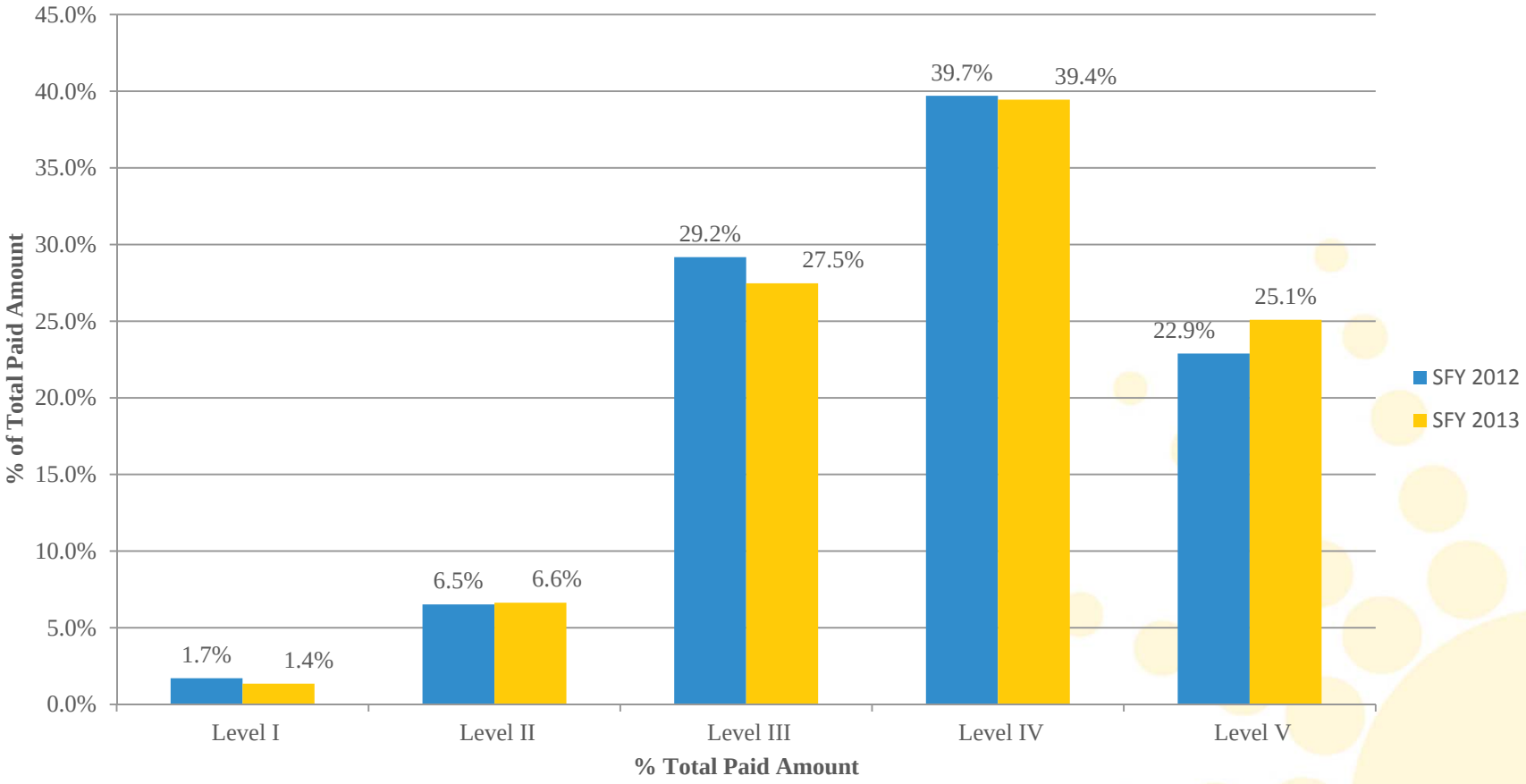
Emergency Department Utilization Report

- Statutorily required report on the use of EDs for nonemergency purposes by AHCCCS enrollees
- Due December 1
- There is no code that identifies whether the services provided in an ED visit were the result of an emergency or non-emergency situation
  - Used the American College of Emergency Physicians' facility coding model to categorize the ED visit data for the State's Medicaid population. Used Level 1 as a proxy for non-emergency services.

ED Utilization: % of Total Visits



ED Utilization: % of Total Paid Amount



AHCCCS
Arizona Health Care Cost Containment System

Reaching across Arizona to provide comprehensive quality health care for those in need

Continued efforts of AHCCCS and its contracted MCOs

Examples include:

- Several MCOs have partnered with Banner Health to establish the Banner Rapid Care Clinic (BRCC) on the campus of Banner Estrella. The BRCC serves as an alternative care setting for lower acuity patients presenting at Estrella's ED
- MCOs and RBHAs meet at least monthly to increase coordination efforts
- All of the MCOs have collaborated with Patient Centered Medical Home practices, especially those that provide expanded hours and accessibility
- Beginning October 1, 2013, AHCCCS amended its Acute Care MCO contracts to include a payment reform initiative that has since been expanded to all MCOs in varying stages of development

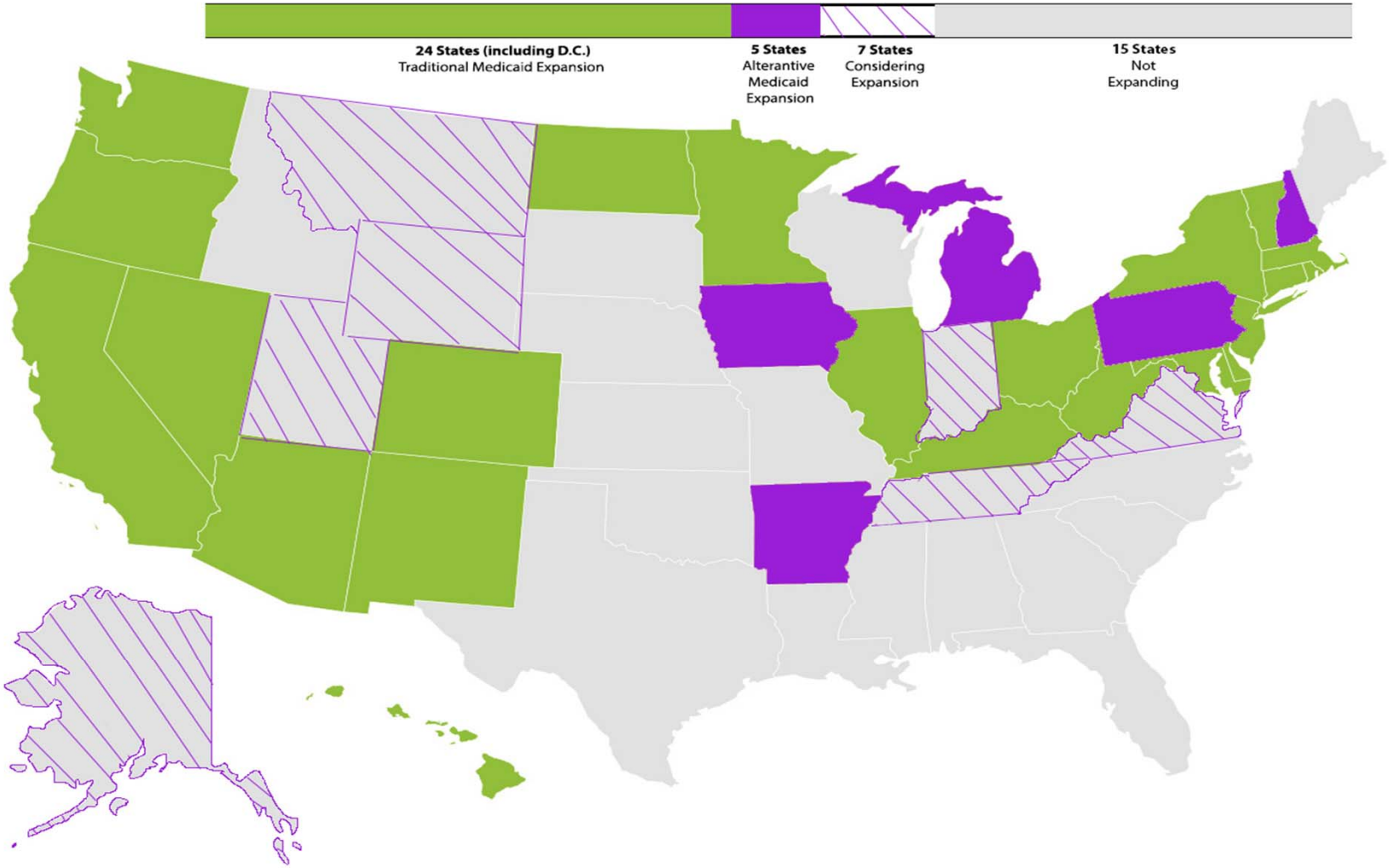
Thank you.

Other State Initiatives

Alternative Medicaid Expansion

Mohamed Arif

Where the States Stand on Medicaid Expansion



Notes: Based on literature review as of 12/17/14. All policies subject to change without notice.

THE HENRY J. KAISER FAMILY FOUNDATION

Key Themes

- The key themes emerging from these non-traditional proposals include:
  1. A preference for a solution relying on private insurance market than on traditional Medicaid
  2. An emphasis on higher enrollee cost-sharing, personal responsibility, and healthy behaviors

Program Design Features

- States have proposed waivers to CMS seeking flexibility in the following areas:
  - FFM and MCO enrollment
  - Premium
  - Copay
  - Health Savings Account (HSA)
  - Ability to Disenroll Beneficiaries/ Non-Compliance
  - Consumer Incentive Programs
  - Work Requirement

Delivery System

Pennsylvania	Michigan	Arkansas	Iowa
Managed Care Organizations (MCOs)	Managed Care Organization MCOs	Federal Facilitate Marketplace (FFM)	FFM Newly Eligible Adults 100-138% FPL
			MCOs Adults 50-100% FPL

Exempt Population

Exempt populations are enrolled in traditional Medicaid program

Pennsylvania	Michigan	Arkansas	Iowa
19 and 20 year olds, medically frail; institutionalized dually eligible, and pregnant women	Individuals residing in ICFs/IID, Seniors age 65 or older, those in counties where a county health plan does not exist.	Medically frail and American Indians/Alaska Natives (unless they elect to be included)	Medically frail and American Indians/Alaska Natives (unless they elect to be included)

Premiums

Pennsylvania	**Newly Eligible Adults >100% FPL**—Parents & Childless Adults **Other Adults >100% FPL**—Parent/caretaker relatives who receive extended Medicaid due to child or spousal support collections, TMA, and those receiving HCBS
Michigan	**Newly Eligible Adults >100% FPL**—Parents & Childless Adults
Arkansas	**No premium payments for beneficiaries**–the state pays monthly premium to QHPs
Iowa	**Newly Eligible Adults >100% FPL**—Parents & Childless Adults

- Premium payments may not exceed 2% of income
- No premium for adults with incomes below 100% FPL

Copays

- Cost sharing (premium and copays) cannot not exceed 5% of household income, as required by federal law.
- **Pennsylvania**
  - **0-100% FPL—**hospital stays ($6/day), drugs ($1 or $3/drug), x-rays ($2/per x-ray), OP psychotherapy ($1/unit), and all other services
  - **>100% FPL—** non-emergency use of the ED ($8)
- **Arkansas**
  - **100-138% FPL**—State Plan copays. Office visit ($2), OP hospital clinic visit ($1), Non ER use of the ER ($3), IP Hospital Stay ($50), Drugs ($1/$3), Chiropractic visit ($1), Dental Visit ($4), Hearing Aid ($3), Podiatric Visit ($2), Vision Visits ($2)
- **Michigan**
  - **0-138% FPL**—IP hospital admission ($50); non-emergency use of the ER, brand-name drugs, dental visit, or hearing aid ($3); physician, podiatry, or vision office visits, $2; outpatient hospital or chiropractic visit or generic drugs ($1)
- **Iowa—50-138% FPL**—non-emergency use of the ED ($8)

Health Savings Account (HSA)

- **Michigan (MI Health Account)**
  - All beneficiary cost-sharing contributions go into the MI Health Account
  - Beneficiaries above 100% FPL are also required to pay a 2% monthly premium into the account
  - Copay and premium requirements paid into the MI Health Account and go directly to the health plans

Ability to Disenroll

- **Iowa**
  - **>100% FPL**—nonpayment of premium results in disenrollment
  - **50-100% FPL**—nonpayment of premium will result in debt subject to collection (no loss of coverage until the time of annual renewal)
- **Pennsylvania (limited)**
  - **>100% FPL**—After 90 day grace period, unpaid premiums becomes collectible debt; members can be disenrolled but are able to *re-enroll without a waiting period*

Non-Compliance

- **Arkansas**
  - **>100% FPL**— can be denied service for failure to pay copay
  - **50-100% FPL**—billed for unpaid copays for services used; if unpaid, it becomes a debt owed to the State
- **Michigan**
  - **0-138% FPL**—State will use various measures to collect payments from beneficiaries who consistently fail to meet payment obligations
    - e.g. garnish state tax returns and access lottery winnings when applicable

Consumer Incentive Program

- **Pennsylvania**
  - All individuals subject to premiums will be eligible to receive a reduction of monthly premiums in year 2 of enrollment if they complete healthy behaviors during year 1 of enrollment (e.g. annual wellness check, timely payments of premiums, etc.)

Consumer Incentive Program Cont.

- **Michigan**
  - Incentives for doing health Risk Assessments and maintain/attain certain healthy behaviors.
    - Beneficiaries (100-133% FPL): receive 50% reduction in monthly contributions estimated to be approximately $120-150 (for one year).
    - Beneficiaries (0-100% FPL): receive a $50 gift card. After a member has accumulated 2% of their income in copays, their subsequent copays will be reduced by 50% (for one year).

Work Requirements

- **Pennsylvania**
  - Proposed work requirements for able-bodied adults working less than 20hrs/week
  - Proposal denied by CMS
- **Indiana**—negotiating with CMS
- **Utah**—proposed work requirement, but withdrew after discussions with CMS

Questions?

Thank You.

Medicaid Adult Coverage Current

These states are all receive 100% Federal matching funds for the new adult population, except for Arizona's Prop 204 childless adult program (0-100% FPL), which receives enhanced federal match at approx. 85%.

Major Waiver Provisions	***Arizona***	***Pennsylvania***	***Michigan***	***Arkansas***	***Iowa***
Non-Emergency Medical Transportation (NEMT)	**Covered** AZ requested a waiver; denied by CMS in Fall 2010	**Waived First Year Only** CMS waived NEMT for newly eligible in DY 1. The state, however, will be responsible to provide these services in DY 2.	**Covered** Waiver not requested	**Covered** Waiver not requested	**Waived First Year Only** CMS waived NEMT for newly eligible in DY 1. The state, however, will be responsible to provide these services in DY 2.
Health Savings Account	**None**	**None**	**MI Health Account** Copay and premium requirements paid into the MI Health Account and go directly to the health plans (funds do not accumulate in the MI Health Account and are not distributed to beneficiaries). Beneficiaries above 100% FPL are also required to pay a 2% monthly premium into the MI Health Account to offset the costs that would otherwise be covered under the Medicaid benefit. All beneficiary cost-sharing contributions into the MI Health	**None**	**None**

Major Waiver Provisions	***Arizona***	***Pennsylvania***	***Michigan***	***Arkansas***	***Iowa***
			Account (including premiums and copays) are limited to 5% of household income, as required by federal law.		
Copays	**Yes** Nominal Copays (1931, YATI, SSI MAO, FTW): Drugs ($2.30), OP ($2.30), other visits ($3.40) Mandatory Copays (TMAs): Drugs ($2.30), Other visits ($4), PT, OT, Speech ($3), OP ($3) Members subject to mandatory copays (TMA) can be denied service for failure to pay copay amount.	**Yes** Medical Assistance: hospital stays ($3/day), drugs ($1 or $3/drug), x-rays ($1/per x-ray), OP psychotherapy ($.50/unit), and all other services (based on the fee Medicaid pays). General Assistance: hospital stays ($6/day), drugs ($1 or $3/drug), x-rays ($2/per x-ray), OP psychotherapy ($1/unit), and all other services (based on the fee Medicaid pays). Newly Eligible Adults with incomes above 100% FPL: In DY1: same as above. In DY2: only copay non-emergency use of the emergency room ($8) Cost sharing (premium	**Yes** Newly Eligible Adults 0-138% FPL: IP hospital admission ($50); non-emergency use of the ER, brand-name drugs, dental visit, or hearing aid ($3); physician, podiatry, or vision office visits, $2; outpatient hospital or chiropractic visit or generic drugs ($1).[1] Cost sharing (premium and copays) may not exceed 5% of household income, as required by federal law.	**Yes** Newly Eligible Adults 100-138% FPL: State Plan copays. Office visit ($2), OP hospital clinic visit ($1), Non ER use of the ER ($3), IP Hospital Stay ($50), Drugs ($1/$3), Chiropractic visit ($1), Dental Visit ($4), Hearing Aid ($3), Podiatric Visit ($2), Vision Visits ($2) Cost sharing (premium and copays) may not exceed 5% of household income, as required by federal law.	**Yes** Newly Eligible Adults 100-138% FPL= Marketplace Choice Plan: Non-Emergency use of the emergency room ($8). Adults 50-100% FPL = Wellness Plan: Non-Emergency use of the emergency room ($8). Cost sharing (premium and copays) may not exceed 5% of household income, as required by federal law.

[1] These copays do not get paid at point of service, but are paid into the MI Health Account

Major Waiver Provisions	***Arizona***	***Pennsylvania***	***Michigan***	***Arkansas***	***Iowa***
		and copays) may not exceed 5% of household income, as required by federal law.			
Premium	**No**	**Yes** Newly Eligible Adults (parents above 100% FPL and newly eligible childless adults above 100% FPL): In DY2: 2% of income Other adults over 100% FPL in DY2 (parent/caretaker relatives who receive extended Medicaid due to child or spousal support collections, TMA, and those receiving HCBS): 2% of income	**Yes** Newly Eligible Adults 100-138% FPL: 2% of income paid directly into the MI Health Account Newly Eligible Adults 0-100% FPL: No premiums.	**No** Newly Eligible Adults (parents b/w 17-138% FPL and newly eligible childless adults 0-138% FPL): The STATE pays monthly premium to QHPs	**Yes** Newly Eligible Adults 100-138% FPL= Marketplace Choice Plan (in 2nd year of eligibility member must enroll in Marketplace): $10/month. Adults 50-100% FPL = Wellness Plan (in 2nd year of eligibility this is part of State's Medicaid program): $5/month *State must grant premium waivers if member self attests to financial hardship (available on premium invoice)

Major Waiver Provisions	***Arizona***	***Pennsylvania***	***Michigan***	***Arkansas***	***Iowa***
Ability to Disenroll Beneficiaries/ Non-Compliance	**None**	**Limited.** 90 day grace period before disenrollment for failure to pay premiums. After 90 days, unpaid premiums becomes collectible debt; members can be disenrolled but are able to *re-enroll without a waiting period*.	**No** State will use various measures to collect payments from beneficiaries who consistently fail to meet payment obligations (e.g. garnish state tax returns and access lottery winnings when applicable).	**No** Newly Eligible Adults 100-138% FPL: can be denied service for failure to pay copay. Newly Eligible Adults 50-100% FPL: Beneficiary is billed for unpaid copays for services used; if unpaid, it becomes a debt owed to the State	**Yes** Newly Eligible Adults 100-133% FPL: Nonpayment of premiums will result in disenrollment Adults 50-100% FPL FPL: Nonpayment of premiums will result in debt subject to collection. No loss of coverage until the time of annual renewal.
Delivery System	**Managed Care Organizations (MCOs)[2]**	**MCOs[3]**	**MCOs[4]**	**Federally Facilitated Marketplace (FFM)[5]**	**FFM (for Newly Eligible Adults 100-138% FPL= Marketplace Choice Plan)** **MCOs (for Adults 50-100% FPL = Wellness Plan)[6]**
Benefits	Beneficiaries receive Alternative Benefit Plan (ABP) adopted as standard State Plan benefit package.	Beneficiaries will receive all of the Essential Health Benefits as required by the Affordable Care	Beneficiaries will receive a full health care benefit package and will include all of the Essential Health	State approved Alternative Benefit Plan (ABP) through a Qualified Health Plan (QHP).	Beneficiaries will be entitled to a State plan Alternative Benefit Plan (ABP) specified in the approved state plan

[2] Except for American Indians/Alaska Natives

[3] Except for: 19 and 20 year olds, medically frail; institutionalized dually eligible, and pregnant women

[4] Except for: Individuals residing in ICFs/IID, Seniors age 65 or older, those in counties where a county health plan does not exist.

[5] Except for: Medically frail and American Indians/Alaska Natives (unless they elect to be included)

[6] Except for: Medically frail and American Indians/Alaska Natives (unless they elect to be included)

Major Waiver Provisions	***Arizona***	***Pennsylvania***	***Michigan***	***Arkansas***	***Iowa***
		Act, including NEMT in DY2, and family planning services.	Benefits as required by federal law and regulation.		through a Qualified Health Plan (QHP). The Iowa Marketplace will provide dental services through a managed care delivery system known as a Prepaid Ambulatory Health Plan (PAHP). Enhanced dental benefits: beneficiaries who complete periodic exam within 6-12 months of first visit and enhanced plus dental benefits if beneficiaries continue periodic exams every 6-12 months. State must assist beneficiaries who timely report that they were unable to obtain a dental appointment and provide access to enhanced benefits for those with a demonstrable need who were unable to access periodic exams.
Consumer Incentives	**None**	**Yes** All individuals subject to premiums will be	**Yes** Incentives for doing Health Risk Assessments	**None**	**None**

Major Waiver Provisions	***Arizona***	***Pennsylvania***	***Michigan***	***Arkansas***	***Iowa***
		eligible to receive a reduction of monthly premiums in year 2 of enrollment if they complete healthy behaviors during year 1 of enrollment (annual wellness check, timely payments of premiums, etc.)	and maintain/attain certain healthy behaviors. <u>Beneficiaries (100-133% FPL):</u> receive 50% reduction in monthly contributions estimated to be approximately $120-150 (for one year). <u>Beneficiaries (0-100% FPL):</u> receive a $50 gift card. After a member has accumulated 2% of their income in copays, their subsequent copays will be reduced by 50% (for one year).		
Work Requirement	**None**	**Requested but denied**	**None**	**None**	**None**

Membership

DATE: Members of the State Medicaid Advisory Committee

TO: AHCCCS Administration

FROM: January 20, 2015

SUBJECT: State Medicaid Advisory Membership

AHCCCS has received requests from individuals and organizations who seek membership on Arizona's State Medicaid Advisory Committee (SMAC). At this time, the SMAC membership is at capacity and there are no vacancies. Upon review of the federal guidelines and Arizona's SMAC bylaws, there is flexibility to add to the membership by amending the bylaws to allow for additional members.

Currently, the SMAC membership is largely represented by provider groups and professional organizations as shown in the attached Membership Roster. It is recommended that the SMAC bylaws be amended to:

- Add 2 new positions that represent AHCCCS recipients, or family members of an AHCCCS recipient, or a community-based organization; and
- 1 new position that represents a provider or professional organization.

Nominations can be submitted by completing and submitting the attached Nomination Form. Appointments will be made by the AHCCCS Director and announced when the positions are filled.

STATE MEDICAID ADVISORY COMMITTEE (SMAC) Nomination Form

Your Name:		
Nominee's Name:		
Address:	***City/State:***	***Zip Code:***
Employer:	***Position/Title:***	
Office Phone Number:	***Fax:***	
E-Mail Address:		
What experience or skills does the nominee have that would be a benefit to the committee?		

Please complete all fields. Mail, Fax, or E-Mail to:
AHCCCS, Office of the Director
801 E. Jefferson St., MD 4100
Phoenix, AZ 85034
Phone: (602) 417-4711
Fax: (602) 256-6756
E-Mail: theresa.gonzales@azahcccs.gov

BYLAWS FOR THE
A.H.C.C.C.S
STATE MEDICAID ADVISORY COMMITTEE (SMAC)

MISSION

The committee will participate in the consideration of AHCCCS policy and programs by reviewing policy, rules and administrative issues. The committee will advise the Director of AHCCCS on policy and administrative issues of concern to the committee member's constituency.

To facilitate accomplishing this mission, the committee will recommend issues to be included on the agenda to allow deliberation of major policy issues prior to their implementation, as much as practicable; receive background information and policy papers prior to meetings, if available; and have the opportunity to discuss issues with AHCCCS Senior Management.

AUTHORITY

The committee operates in accordance with 42 CFR 431.12 and the State Medicaid Plan.

DEFINITIONS

"Administration" means the Arizona Health Care Cost Containment System (AHCCCS) as defined in Arizona Revised Statutes (A.R.S.) §§ 36-2901, 36-2931, 36-2971 and 36-2981.

"Committee" means the State Medicaid Advisory Committee, as appointed by the Director.

"Director" means the Director of AHCCCS as specified in A.R.S. §§ 36-2901, 36-2931, 36-2971 and 36-2981.

COMMITTEE COMPOSITION

The committee shall include the AHCCCS Director or designee, the DHS Director or a designee, and the DES Director or a designee; ~~six~~seven (~~6~~7) health care providers or professionals with a direct interest in the AHCCCS program; and ~~six~~eight (~~6~~8) members of the public (such as a Medicaid recipient, a consumer advocate, a representative of a tribal community, or a representative of the educational community).

APPOINTMENT PROCESS AND LENGTH OF TERM

The AHCCCS Director or a designee, the DHS Director or a designee, and the DES Director or a designee positions are ex-officio. The remaining ~~12~~15 committee members shall be appointed by the AHCCCS Director for two, two year terms.

The AHCCCS Director or a designee is the committee's chairperson and is responsible for setting meeting agendas. The chairperson can call special meetings. The chairperson shall preside at all meetings, and shall facilitate discussion by the members.

The committee may submit to the Director a list of nominees for expiring terms. The Director may solicit or receive nominations from other sources.

STAFF ASSISTANCE

Staff assistance from the Administration shall be available to the committee at the request of the chairperson or the full committee. The designated SMAC Manager shall provide staff assistance. The SMAC Manager can be reached by phone at (602) 417-4732 or 1-800-654-8713 ext. 4732. Independent technical assistance shall be available at the request of the full committee, if determined necessary by the Director and funds are available.

MEETINGS

Meetings shall be held quarterly on the 2nd Wednesday of February, April, July and October, or upon the call of the Director.

If a committee member is unable to attend a meeting, the member is requested to notify the SMAC Manager of their absence prior to the date of the meeting. Members are encouraged to send a representative to meetings they are unable to attend. Members are requested to notify the SMAC Manager with the name of the individual who will be attending on their behalf. The SMAC meetings are open to the public.

MEETING MATERIALS

When available, handouts for the current agenda will be mailed two weeks in advance of the meeting. Members shall bring all mailed handouts to the meeting to facilitate discussion.

If a member is unable to attend the meeting and is sending a representative, please forward the handouts to the representative to bring to the meeting.

FEDERAL FINANCIAL PARTICIPATION

Medicaid recipient members shall be reimbursed for necessary costs, such as transportation and childcare, to facilitate their attendance at committee meetings.

If determined necessary and available by the AHCCCS Director, Federal financial participation at 50 percent shall be secured for expenditures for the participation of the Medicaid recipient members and for committee activities, including independent technical assistance costs.

42 Code of Federal Regulations (CFR)

Part 431-State Administration
Subpart A-Single State Medicaid Agency

42 CFR 431.12 § 431.12 Medical care advisory committee.

(a) Basis and purpose. This section, based on section 1902(a)(4) of the Act, prescribes State plan requirements for establishment of a committee to advise the Medicaid agency about health and medical care services.

(b) State plan requirement. A State plan must provide for a medical care advisory committee meeting the requirements of this section to advise the Medicaid agency director about health and medical care services.

(c) Appointment of members. The agency director, or a higher State authority, must appoint members to the advisory committee on a rotating and continuous basis.

(d) Committee membership. The committee must include –

(1) Board-certified physicians and other representatives of the health professions who are familiar with the medical needs of low-income population groups and with the resources available and required for their care;

(2) Members of consumers' groups, including Medicaid recipients, and consumer organizations such as labor unions, cooperatives, consumer-sponsored prepaid group practice plans, and others; and

(3) The director of the public welfare department or the public health department, whichever does not head the Medicaid agency.

(e) Committee participation. The committee must have opportunity for participation in policy development and program administration, including furthering the participation of recipient members in the agency program.

(f) Committee staff assistance and financial help. The agency must provide the committee with –

(1) Staff assistance from the agency and independent technical assistance as needed to enable it to make effective recommendations; and

(2) Financial arrangements, if necessary, to make possible the participation of recipient members.

(g) Federal financial participation. FFP is available at 50 percent in expenditures for the committee's activities.

State Medicaid Advisory Committee Members (as of October 21, 2014)

First Name	Last Name	Title	Organization				Term dates
Ex-Officio Members							
Thomas	**Betlach**	Director	AHCCCS				N/A
Will	**Humble**	Director	Arizona Department of Health Services				N/A
Kathy	**Waite**	DES/AHCCCS Liaison	Arizona Department of Economic Security				N/A
Provider/Professional Members							
Kathy	**Byrne**	Executive Director	El Rio Community Health Center				**Term:** 2/2014 – 2/2016
Tara	**McCollum Plese**	Director of Government & Media Relations	Arizona Association of Community Health Centers				**Term:** 2/2014 – 2/2016
Kevin	**Earle, MBA, MPH**	Executive Director	Arizona Dental Association				**Term:** 4/2013 – 4/2015
Kathleen	**Collins Pagels**	Executive Director	Arizona Health Care Association				**Term:** 7/2013 – 7/2015
Amanda	**Aguirre**	CEO / President	Regional Center for Border Health				**Term:** 4/2013 - 4/2015
Peggy	**Stemmler, M.D.**	Pediatrician and Consultant	Arizona Academy of Pediatrics and Stemmler and Associates				**Term:** 4/2014 – 4/2016

State Medicaid Advisory Committee Members (as of October 21, 2014)

First Name	Last Name	Title	Organization				Term dates
Public Members							
Kim	**VanPelt**	Associate Director	St. Luke's Health Initiative				**Term:** 7/2013 – 7/2015
Leonard	**Kirschner, M.D., M.P.H.**	Board Member	Arizona Perinatal Trust				**Term:** 2/2013 – 2/2015
Phil	**Pangrazio**	Executive Director	AZ Bridge for Independent Living				**Term:** 2/2014 – 2/2016
Steve	**Jennings**	State Director	AARP Arizona				**Term:** 7/2014 - 7/2016
Tomás	**León**	Chief Executive Officer	People of Color Network				**Term:** 2/2013 - 2/2015
Vernice C. (Cheri)	**Sampson**	Senior Pastor	Salt River Assembly of God				**Term:** 1/2015 - 1/2017

Committee Composition

The committee shall include the Director or a designee, the DHS Director or a designee, and the DES Director or a designee; six health care providers or professionals with a direct interest in the AHCCCS program; and six members of the public (such a Medicaid recipient, a consumer advocate, a representative of a tribal community, or a representative of the educational community).

Appointment Process and Length of Term

The Director or a designee, the DHS Director or a designee, and the DES Director or a designee positions are ex-officio. The remaining 12 committee members shall be appointed by the Director for two, two year terms. The AHCCCS Director or a designee is the committee's chairperson and is responsible for setting meeting agendas. The chairperson can call special meetings. The chairperson shall preside at all meetings, and shall facilitate discussion by the members. The committee may submit to the Director a list of nominees for expiring terms. The Director may solicit or receive nominations from other sources.

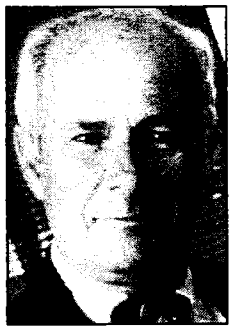
Call to the Public

Happy anniversary 2015!

GUEST COMMENTARY

by Leonard Kirschner

Americans love anniversaries whether it is the birth of our nation on July Fourth, the end of the Civil War and assassination of President Abraham Lincoln in 1865, our parents 50th, Pearl Harbor or Sept. 11. The year 2015 has a number of significant anniversaries of laws that have changed American society in uncountable ways. A short review of the past 80 years.



Leonard Kirschner

On Aug. 14, 1935, in the height of the Great Depression, President Franklin Delano Roosevelt signed Social Security into law. Opponents fought long and hard to stop passage calling it "Socialism." Ida May Fuller received the first Social Security check for the grand sum of $22.45. We now celebrate the 80th anniversary of Social Security.

July 30, 2015, is the 50th anniversary of the historic signing of Medicare and Medicaid into law by President Lyndon Johnson. The ceremony took place at the Truman Library in Independence, Mo., and Harry Truman got Medicare card No. 1. His premium for Part B was $3 per month. LBJ spoke only about Medicare and declared it a memorial to the slain JFK. Medicaid was an afterthought, added at the last moment before the law was passed by a divided Congress, and was intended to be a rather modest program with minimal financial impact. Congressional opposition was fierce calling it, once again, "Socialism." Arizona waited 17 years to implement Medicaid and had the distinction of being last in the nation.

By the early 1970s, health care costs were rapidly rising. Sen. Ted Kennedy proposed a new model of health care called HMO. President Richard Nixon bought into the proposal and signed the law, proposed by Kennedy, on Dec. 29, 1973. Opponents on the right called it "Socialism" while on the left it was called "Capitalism" as it was bringing the for-profit world into the nonprofit health care arena. It was bi-partisan and we now have United, Aetna, Cigna, Humana and a host of other publically traded companies dominating health care.

Thirty years ago, on July 31, 1985, legislation was introduced that included the Emergency Medical Treatment and Active Labor Act (EMTALA). The law was supported by and signed by President Ronald Reagan. The law required that hospital emergency departments must provide care to any person presenting in the ED regardless of citizenship, legal status or ability to pay. There was no funding provided and it remains an unfunded mandate and controversial to this day. Opposition was present from right and left and, once again, some called it "Socialism" while others shouted "Capitalism."

It was July 26, 1990, when President George H. W. Bush signed the Americans with Disabilities Act into law. The event took place on the South Lawn of the White House and the president considered it an extension of the Civil Rights Act of 1965. He said, "Let the shameful wall of exclusion finally come tumbling down." The signing was the culmination of a quarter century of advocacy by and for the members of our society with disabilities. Some opponents called it "Socialism." We now celebrate the 25th anniversary of this law.

It was 1993 and a new president took office. First order of business was reforming the U.S. health care system. President Bill Clinton appointed his wife, Hillary Clinton, to lead the charge. Most of us remember the contentious battle that shook the nation over the next 18 months. No law passed and the Republican Party captured the Congress in the mid-term election. President Clinton did sign one major piece of health care legislation called HIPAA and we have all filled out numerous HIPAA forms in our visits to doctors and hospitals. The law was bi-partisan and introduced by Sen. Nancy Kassenbaum, Republican of Kansas.

President George W. Bush signed the Medicare Prescription Drug, Improvement, and Modernization Act on Dec. 8, 2003. The law is better known as Medicare Part D and passage was hotly debated. It looked as though the law would fail in the House and voting was kept open for hours looking for a few members to switch from no to yes. Rep. Trent Franks changed his vote and the law passed. Enrollment began 10 years ago, in 2005, and the law is quite popular today. The opponents used the same words to fight passage as we have seen for decades in other battles.

Can you believe it has been five years since President Barack Obama signed the Affordable Care Act into law on March 23, 2010? I don't believe I need to recount the battles leading up to the passage and subsequent battles to repeal and replace. Opponents, when not talking about "Death Panels," called it "Socialism."

As we celebrate the 80th anniversary of Social Security, the 50th anniversary of Medicare and Medicaid, the 25th anniversary of the ADA, the 10th anniversary of Part D and the fifth anniversary of the ACA, remember that the passage of these six laws took years of effort, advocacy and politics to achieve the end result of passage. And also don't forget that once the laws were signed, the political battles did not end. So stay tuned for 2015 and the 2016 presidential election. The debate has not ended and will not in our lifetime.

Leonard Kirschner is a member of the Arizona State Medicaid Advisory Committee and the Harvard School of Public Health Leadership Council and is on the Board of Directors for the Wickenburg Community Hospital. He was the past president of AARP Arizona, and was the director of AHCCCS from 1987 to 1993.