ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM

Arizona Section 1115 Demonstration Waiver—COVID-19 PHE CHIP Amendment

Evaluation Report

June 2025

HSAG HEALTH SERVICES ADVISORY GROUP

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Executive Summary

The Centers for Medicare & Medicaid Services (CMS) approved the coronavirus disease 2019 (COVID-19) public health emergency (PHE) amendment (the Amendment) to the Arizona Health Care Cost Containment System (AHCCCS) Section 1115 demonstration (11-W-00275/9) on June 7, 2023.[1] The Amendment allowed Arizona to provide continued eligibility for Children's Health Insurance Program (CHIP) members who were determined to be ineligible for CHIP due to a change in circumstances and who were otherwise ineligible for Medicaid due to income above 133 percent of the federal poverty level (FPL). The Amendment was retroactive from March 1, 2020, through the end of the redetermination process, ending on March 31, 2024.[2]

Methodology

A mixed-methods approach was employed to evaluate the Amendment using both qualitative data from key informant interviews with AHCCCS staff, and quantitative data consisting of eligibility, enrollment, and claims/encounter data. Table 1 outlines the research questions examined and the analytic methods used.

Table 1—Research Questions and Analytic Methods

Research Question	Analytic Method
RQ 1.1: What challenges did the State encounter when implementing the expenditure authority?	Qualitative Analysis
RQ 1.2: What facilitators of success did the State encounter when implementing the expenditure authority?	Qualitative Analysis
RQ 1.3: How many CHIP members were impacted by the demonstration?	Descriptive Analysis
RQ 1.4: What were the expenditures associated with providing continuous eligibility for CHIP members?	Descriptive Analysis

Note: CHIP: Children's Health Insurance Program; RQ: research question

Results and Conclusions

The expenditure authority allowing CHIP members to maintain continuous eligibility throughout the COVID-19 PHE assisted the State in achieving the key goals, including reducing enrollment churn, minimizing confusion among members, and lowering barriers to care for children during the PHE.

Nearly 100,000 CHIP members retained enrollment at some point during the PHE under the Amendment authority. Additionally, the total cost of care for members whose eligibility was in "override" status was comparable to that of CHIP members who were eligible for coverage without the override status.

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1 Centers for Medicare & Medicaid Services. COVID-19 CHIP Demonstration Amendment Approval. Available at: https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/az-coid-chip-demonstn-aprl-ca.pdf. Accessed on: Jan 13, 2025.

2 Arizona Health Care Cost Containment System. Eligibility Dashboard. Available at: https://www.azahcccs.gov/AHCCCS/Downloads/COVID19/Arizona_Eligibility_Dashboard.pdf. Accessed on: Jan 13, 2025.

State administrators reported challenges with developing and aligning data systems to track members' eligibility status and determine whether they met the override criteria. However, once these systems and processes were in place, AHCCCS indicated that utilizing a newly created reporting system assisted in actuarial calculations and more accurate budget development.

Lessons Learned and Best Practices

AHCCCS staff indicated that one particularly successful best practice of the demonstration was CMS allowing flexibility during the waiver application process and providing a pre-populated application template. This allowed AHCCCS to submit the application and receive timely approval from CMS.

Another lesson learned was the challenge of creating a mechanism for allowing eligibility override during the PHE. Incorporating such a mechanism into the routine management of Medicaid and CHIP eligibility could eliminate the need for states to develop special mechanisms to track continuous eligibility in similar situations. Additionally, this approach could alleviate occasional instances in which members were discontinued when they should have remained eligible.

AHCCCS leadership created a dedicated work group to address COVID-19 PHE policies. This group included representatives from various State agencies, each with decision-making capabilities. Their involvement reduced potential delays and assisted in the development and implementation of policies while maintaining compliance with federal regulations.

1. Introduction

On May 3, 2023, Arizona submitted a request to the Centers for Medicare & Medicaid Services (CMS) for an amendment to the Arizona Health Care Cost Containment System (AHCCCS) Section 1115 demonstration (11-W-00275/9) in order to address the coronavirus disease 2019 (COVID-19) public health emergency (PHE) (the Amendment).[1-1] CMS approved the Amendment to the AHCCCS Section 1115 Waiver Demonstration on June 7, 2023.[1-2] The Amendment was retroactive from March 1, 2020, through the end of the redetermination process, which ended on March 31, 2024.[1-3]

Amendment Background and Goals

The goal of the Amendment was to ensure that Children's Health Insurance Program (CHIP) members maintained continuous eligibility during the COVID-19 PHE. The Amendment allowed Arizona to provide continued eligibility for CHIP members who were determined to be ineligible for CHIP due to a change in circumstances and who were otherwise ineligible for Medicaid due to income above 133 percent of the federal poverty level (FPL) during the demonstration period. The Amendment assisted the State in delivering the most effective care to its members during the COVID-19 PHE, as well as supported the key objective of furnishing medical assistance in a way that is intended to protect, to the greatest extent possible, the health, safety, and welfare of individuals and providers who were potentially affected by the COVID-19 PHE.

Hypotheses and Research Questions

The core objective of the evaluation of the Amendment was to test whether and how the Amendment and expenditure authorities mitigated any potential negative impacts of the COVID-19 PHE. The hypothesis and research questions listed in Table 1-1 were tailored to assess this objective.

Table 1-1—Hypothesis and Research Question

Hypothesis 1: The pause on redeterminations for the CHIP population promoted the objectives of Medicaid.
RQ 1.1: What challenges did the State encounter when implementing the expenditure authority?
RQ 1.2: What facilitators of success did the State encounter when implementing the expenditure authority?
RQ 1.3: How many CHIP members were impacted by the demonstration?
RQ 1.4: What were the expenditures associated with providing continuous eligibility for CHIP members?

Note: CHIP: Children's Health Insurance Program; RQ: research question

[1-1] Section 1115 Demonstration Waivers allow states flexibility in how healthcare is provided within the state, within federal guidelines. CMS has designed a national evaluation strategy to ensure that demonstrations meet program objectives and to inform Medicaid policy in the future.

[1-2] Centers for Medicare & Medicaid Services. COVID-19 CHIP Demonstration Amendment Approval. Available at: https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/az-coid-chip-demonstn-aprl-ca.pdf. Accessed on: Jan 13, 2025.

[1-3] Arizona Health Care Cost Containment System. Eligibility Dashboard. Available at: https://www.azahcccs.gov/AHCCCS/Downloads/COVID19/Arizona_Eligibility_Dashboard.pdf. Accessed on: Jan 13, 2025.

2. Methodology

To assess the impact of the coronavirus disease 2019 (COVID-19) public health emergency (PHE) Children's Health Insurance Program (CHIP) amendment (the Amendment) to the Arizona Health Care Cost Containment System (AHCCCS) Section 1115 Demonstration Waiver, the evaluation primarily consisted of qualitative data collection and descriptive reporting of costs.[2-1] As such, the methods of analysis centered on qualitative synthesis and descriptive data analysis. The Centers for Medicare & Medicaid Services (CMS)-approved evaluation design is available in Appendix A.

Intervention and Comparison Populations

The population impacted by the Amendment included all CHIP members who were determined ineligible for CHIP due to a change in circumstances and who were otherwise ineligible due to income above 133 percent of the federal poverty line (FPL) during the evaluation period. Members were excluded from the waiver if they met any of the following criteria:

- Deceased
- Voluntarily withdrew from benefits
- No longer Arizona residents
- Not eligible during the demonstration period but were approved erroneously because of agency error or fraud or abuse attributed to the member or member's representative
- Turned 19 years of age during the evaluation period

AHCCCS provided a data file that was used to capture members who were able to maintain continuous eligibility through the Amendment. The data file was reconciled with the overall CHIP/Medicaid eligibility data to identify the final intervention population. During this process, approximately 2 percent of override members from the data file were excluded from the final intervention population.

Due to the limited nature of the Amendment, no comparison group was used in the evaluation.

Evaluation Period

Approved on June 7, 2023, the Amendment was retroactive from the start of the PHE on March 1, 2020, through the end of the unwinding period on March 31, 2024.[2-2] This period, from March 1, 2020, through March 31, 2024, represents the evaluation period for this Amendment.

2-1 Centers for Medicare & Medicaid Services. Approved Evaluation Design. Available at: https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/az-cms-approved-covid-19-chip-evaluation-design.pdf. Accessed on: Jan 13, 2025.

2-2 Centers for Medicare & Medicaid Services. COVID-19 CHIP Demonstration Amendment Approval. Available at: https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/az-coid-chip-demonstn-aprl-ca.pdf. Accessed on: Jan 13, 2025.

Evaluation Measures

Table 2-1 presents the evaluation measures along with the data sources and analytic approaches that were used to evaluate the Amendment. Full measure specifications are presented in the Appendix.

Table 2-1—Evaluation Measures

RQ	Measure(s)	Data Source(s)	Analytic Approach
1.1	1-1: Reported challenges that AHCCCS encountered when implementing the expenditure authority.	Key informant interviews	Qualitative synthesis
1.2	1-2: Reported successes that AHCCCS encountered when implementing the expenditure authority.	Key informant interviews	Qualitative synthesis
1.3	1-3: Number and percentage of CHIP members.	PMMIS	Descriptive analysis
1.4	1-4: Administrative costs associated with implementing and maintaining the expenditure authority.	Administrative records	Descriptive analysis
	1-5: Monthly per-member expenditures among CHIP members who would have been ineligible if not for the expenditure authority.	PMMIS	Descriptive analysis

Note: AHCCCS: Arizona Health Care Cost Containment System; CHIP: Children's Health Insurance Program; PMMIS: Pre-paid Medical Management Information System; RQ: research question

Data Sources

The data used in the Report included data to track and maintain individuals impacted by the waiver Amendment (i.e., the "override" population), as well as CHIP/Medicaid enrollment and eligibility data, demographic data, claims and encounter data, and key informant interviews with AHCCCS staff.

The data sources used in the Evaluation Report have several strengths, making them suitable for the evaluation. Key informant interviews provided valuable context for how the demonstration was implemented and evolved over time, including drivers of success, areas of concern, and changes to the quality of or access to care during the demonstration.

In summary, the examination of both qualitative and quantitative data allows for an integrative, holistic assessment of the Amendment's effects, providing a more rigorous and robust analysis than either data type could offer on its own.

Administrative Data

Administrative data extracted from the Prepaid Medical Management Information System (PMMIS) were used to calculate three measures in this evaluation. These data included administrative claims/encounter data, member eligibility, enrollment, and demographic data. Additionally, AHCCCS provided a data file containing information on the override population, which was used to identify members who were able to maintain continuous eligibility through the Amendment.

Key Informant Interviews

Key informant interviews with AHCCCS staff administrators were conducted using semi-structured interview protocols. The interviews were transcribed and imported into MAXQDA, where the data were coded for

qualitative analysis. Interviews with five AHCCCS staff members were conducted in September 2024. The purpose of the interviews was to capture qualitative insights about successes and challenges AHCCCS encountered while implementing the Amendment. The transcripts, coding methodology, and coded data were used to address two of the research questions.

Analytic Methods

Two analytic techniques were used, depending on the type of data for the measure and the availability of the data.

Descriptive Analysis

To address Research Questions 1.3 and 1.4, descriptive analysis was used to assess the changes in measures during the evaluation period. This analysis aimed to identify substantive changes in enrollment continuity and associated costs over time for CHIP members impacted by the Amendment.

To calculate cost of care for Research Question 1.4, paid encounters were identified across all categories of service (i.e. institutional, professional, dental, and pharmacy). Total monthly costs were calculated by using the health plan amount paid to providers as recorded on the encounters. Only paid claims were included in this analysis. PMPM costs among override members were calculated by dividing the total monthly cost by the total member-months with an override status for each month.

The 95 percent confidence intervals were calculated by applying the following formula to PMPM costs:

$$\bar{x_t} \pm 1.96 * \frac{s_t}{\sqrt{n_t}}$$

where $\bar{x}$ refers to the PMPM cost in month t, s refers to the sample standard deviation of members' total monthly cost, and n refers to the total member-months with an override status.

Qualitative Synthesis

A series of key informant interviews with AHCCCS staff were conducted to better understand the challenges presented by the COVID-19 PHE to the CHIP and Medicaid programs, how flexibilities of the Amendment assisted in meeting those challenges, and the lessons learned for responding to similar PHEs in the future (Research Questions 1.1 and 1.2). Interviewees were selected from nominees identified by AHCCCS.

The information gathered from these interviews was synthesized with results from other quantitative data analyses, offering an in-depth discussion of each domain/objective. As the interviews were conducted, the independent evaluator performed an ongoing, iterative review of the responses and notes to identify emerging themes and common patterns. The preliminary findings were used to document the overarching themes related to the research questions.

After completing the interviews, the notes and transcripts were reviewed using standard qualitative analysis techniques. The data were examined through open coding to identify key concepts and themes that may not have emerged during previous analyses. After identifying these concepts, axial coding techniques were applied to develop a more complete understanding of the relationships among categories identified by respondents. Open and axial coding were focused on identifying the dimensionality and depth of responses to the research questions.

The coded data were used to synthesize the interviews and summarize State administrators' experiences with the Amendment.

Methodological Limitations

The COVID-19 PHE CHIP Amendment Report includes multiple data sources, methods, and metrics, each with strengths that support the validity and reliability of the results. In contrast, each element also has inherent limitations that restrict the ability to provide a comprehensive evaluation of the Amendment. This section outlines the strengths and weaknesses of the data sources, methods, and metrics used in this report.

Data Sources

Because the methodologies used in this evaluation were descriptive in nature, the primary limitations involve quality of data collection.

AHCCCS provided a data file that captures members who maintained continuous eligibility through the Amendment. Approximately 2 percent of override members in the data file were excluded from the final intervention population due to missing CHIP/Medicaid eligibility data. This exclusion may have implications on the generalizability of the evaluation results, especially if the excluded members had systematically different health care needs from those included in the final intervention population.

Additionally, the estimated administrative costs provided by AHCCCS were based on proportional enrollment of the CHIP population. These estimated costs may not have been reflective of the actual costs for the specific CHIP program.

Additionally, the qualitative analysis did not provide a statistically representative sample of experiences with the Amendment. Instead, the responses gathered through stakeholder interviews were aimed to provide context and capture the breadth and variety of experiences among key stakeholders. The experiences of AHCCCS staff who were not interviewed may differ from those described in the report.

Methods

Descriptive analysis was used to summarize and visualize the per-member per-month (PMPM) costs. While this analysis is straightforward to understand and interpret, it has limitations for making causal inferences regarding the impact of the Amendment. Although the calculation of PMPM costs for CHIP members who maintained continuous eligibility due to the Amendment (i.e., the override group) and those who were not included in the override group was feasible, this descriptive analysis does not provide a sufficiently strong comparison to definitively conclude whether the Amendment had an effect on PMPM costs over time.

The Amendment allows the authority to provide continued eligibility for CHIP members who were determined to be ineligible for CHIP due to a change in circumstances during the demonstration. The goal of the Amendment was to ensure that the most effective care is delivered to CHIP members during the COVID-19 PHE. Despite the flexibilities provided by the Amendment, there may be certain limitations to consider for this evaluation. For example, the COVID-19 PHE may have introduced unpredictable impacts that could have influenced the evaluation outcomes in unforeseen ways, such as potentially affecting PMPM costs during months in which non-essential medical services were limited. Additionally, due to the limited nature of the Amendment, there is no

comparison group or baseline data for the purpose of this evaluation, limiting the ability to draw causal inferences regarding the impact of the Amendment.

There were six other programs in operation simultaneously with the Amendment as a part of the AHCCCS Section 1115 Demonstration Waiver. As such, the potential for confounding effects from these other programs when evaluating the impact of the Amendment cannot be definitively isolated. However, the effects of confounding from these other waiver programs are expected to be minimal, as the Amendment targeted CHIP members, which are covered by a separate program (KidsCare) from Title XIX Medicaid.

3. Results

The following section details measure results by hypotheses and related research questions for the coronavirus disease 2019 (COVID-19) public health emergency (PHE) Children's Health Insurance Program (CHIP) amendment (the Amendment) to the Arizona Health Care Cost Containment System (AHCCCS) Section 1115 Demonstration Waiver. Details on measure definitions and specifications can be found in the Appendix.

Results Summary

Hypothesis 1: The pause on redeterminations for the CHIP population promoted the objectives of Medicaid.

Research Question (RQ) 1.1: What challenges did the State encounter when implementing the expenditure authority?

RQ 1.2: What facilitators of success did the State encounter when implementing the expenditure authority?

RQ 1.3: How many CHIP members were impacted by the demonstration?

RQ 1.4: What were the expenditures associated with providing continuous eligibility for CHIP members?

Reported challenges that AHCCCS encountered when implementing the expenditure authority (Measure 1-1)

State administrators discussed several challenges encountered during the implementation of the Amendment during key informant interviews. One significant issue was the administrative burden of tracking members who maintained Medicaid eligibility under the Families First Coronavirus Response Act (FFCRA) continuous eligibility provisions. AHCCCS developed and validated a process to track "override" members who maintained eligibility due to FFCRA, ensuring that members who later reestablished eligibility were removed from the override system. This validation process was necessary to ensure compliance with federal regulations, but it added to the workload, contributing to the overall administrative burden. Additionally, State administrators highlighted that some members' eligibility statuses were not located in the primary online eligibility system. Instead, their eligibility status was only located in the Prepaid Medicaid Management Information System (PMMIS). This required the development of a solution to transfer members' eligibility data from the PMMIS to the primary online eligibility system.

When the COVID-19 PHE concluded and the Medicaid unwinding process began in April 2023, approximately 675,000 members were a part of the COVID-19 PHE override group.[3-1] Members placed in the override group had been removed from the standard renewal/redetermination process, leading to inconsistencies in eligibility determination dates for members within the same household. In addition, AHCCCS struggled to identify and evenly distribute redeterminations over the planned 12-month span. As a result, the initial unwinding timeline was extended by six months to comply with federal regulations, which required all states provide 12 months of continuous eligibility for children enrolled in CHIP. Informants also described budgetary challenges during the Amendment implementation, particularly determining how quickly members would lose Medicaid coverage during the unwinding process.

[3-1] Arizona Health Care Cost Containment System. AHCCCS Meets End-of-Year Renewal Deadline. Available at: https://www.azahcccs.gov/shared/News/PressRelease/RenewalDeadlineMet.html. Accessed on: Jan 13, 2025.

State administrators shared initial challenges maintaining awareness of the policies associated with the COVID-19 PHE and the Amendment, primarily due to the novelty of the response. Staff faced difficulties managing the continuous eligibility provision, which occasionally led to unintended discontinuations for members who should have remained eligible.

Reported successes that AHCCCS encountered when implementing the expenditure authority (Measure 1-2)

State administrators described successes encountered in the development and implementation of the Amendment. One State administrator shared that the Centers for Medicare & Medicaid Services (CMS) was flexible during the Amendment application process, providing pre-populated templates and examples of approvals from other states with similar applications. As a result, AHCCCS was able to submit its application promptly, and it received timely approval from CMS.

AHCCCS reduced unnecessary system bifurcation by integrating the primary online eligibility system and PMMIS. Members whose eligibility was only listed in the PMMIS were transferred to the primary online eligibility system using an existing process initially designed for tracking Supplemental Security Income (SSI) Cash members. When PMMIS-only members were moved to the primary online eligibility system they were given a six-month eligibility extension to ensure that they were processed in the system before their eligibility expired.

In order to accurately identify and track the Amendment population, State administrators worked with an eligibility system vendor and other State partners to develop a redetermination process reporting system. This reporting system aided AHCCCS in completing CMS-required reporting and publishing the public online dashboard. Actuaries also used the reporting system to develop risk adjustments and examine the data at a health-plan level to determine if one health plan was disproportionately impacted by the Amendment.

Throughout the development and implementation of the Amendment, State administrators promoted clarity and transparency. For example, the identification and tracking system provided members and stakeholders an in depth understanding of the unwinding process by outlining the reasons members' eligibility was discontinued.

AHCCCS provided State administrators and staff at partner agencies with educational materials to address knowledge gaps about the policies associated with the COVID-19 PHE and the Amendment. AHCCCS leadership also closely monitored discontinuances. In the event of a sudden increase in discontinuances, State administrators sent outreach to staff with information about the active policies to ensure that all discontinuances were valid.

AHCCCS leadership created a dedicated work group to address COVID-19 PHE policies, bringing together representatives from operations, policy, and system administrators from various State agencies. This work group reduced potential delays and aided in the development and implementation of policies while maintaining compliance with federal regulations. At the height of the COVID-19 PHE, the work group was held weekly for up to two hours.

State administrators also shared successes associated with budgeting. One State administrator noted that the Amendment facilitated budget development by allowing for accurate forecasting of the enrolled population. Another State administrator felt that the Amendment benefited the State's economy.

> *"I think they [the Amendment's successes] are exactly what we intended them to be: reduced churn, reduced confusion, [and] eliminating barriers to accessing care for children and their families during the [COVID-19] PHE."*

Members' financial circumstances fluctuated throughout the COVID-19 PHE, making members more susceptible to churn—the temporary loss of coverage when members disenroll and then re-enroll within a short period of time. State administrators reported that the Amendment contributed to a successful reduction in churn, thereby reducing gaps in members' coverage and ensuring that members with fluctuating economic circumstances maintained continuity of care.

Number and percentage of CHIP members (Measure 1-3)

Figure 3-1 displays the percentage of CHIP members who were provided continued eligibility through the Amendment despite being ineligible due to a change in circumstances and who were otherwise ineligible for CHIP due to income above the federal poverty level (FPL) during the demonstration period (i.e., the override group). The percentage of CHIP members included in this override grew to approximately 25 percent over the evaluation period. This percentage peaked at nearly one-third of CHIP members in March 2022, then started to decline in April 2023 as the unwinding process began.

Figure 3-1—Percentage of CHIP Members Maintaining Continuous Eligibility Due to the Amendment

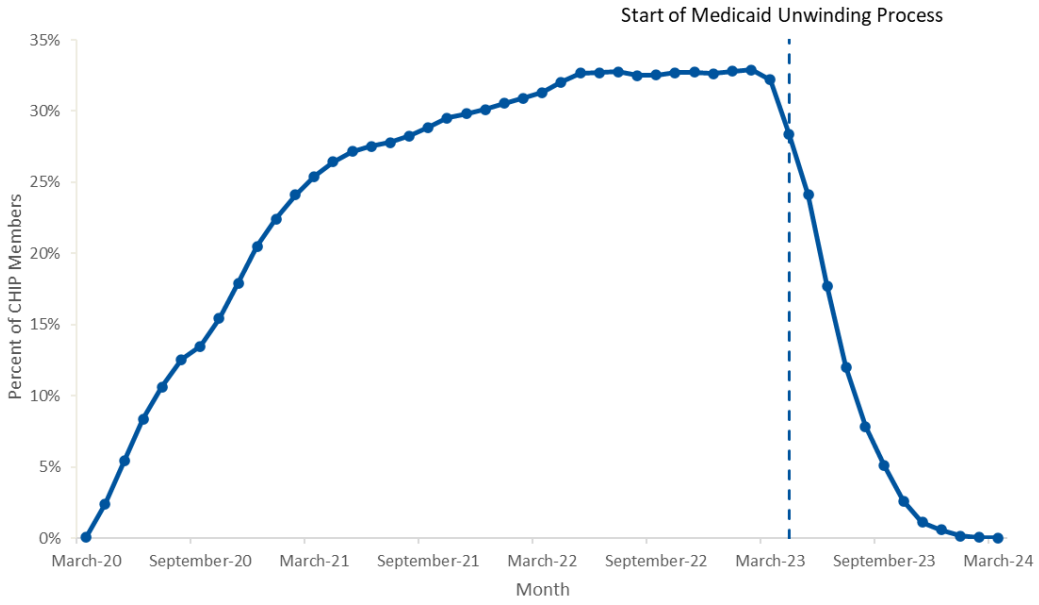
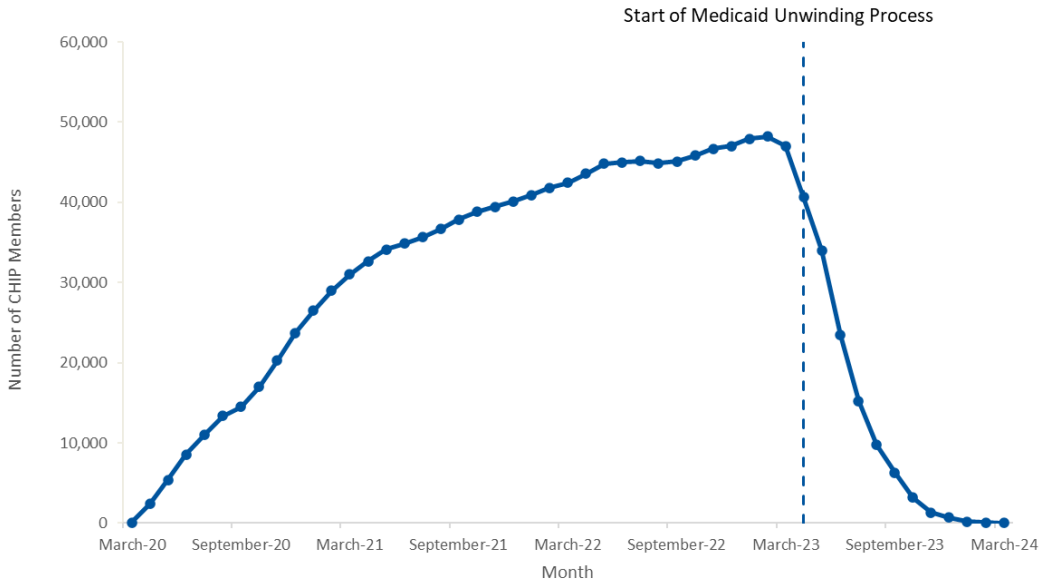


Figure 3-2 displays the number of CHIP members who were in the override group. While rates of CHIP members in the override group remained level from March 2022 through March 2023, the number of CHIP members in the override group increased slightly during this time. This suggests that the total number of CHIP members also increased during this timeframe.

Figure 3-2—Number of CHIP Members Maintaining Continuous Eligibility Due to the Amendment



Administrative costs associated with implementing and maintaining the expenditure authority (Measure 1-4)

AHCCCS reported $24,859.92 spent in administrative costs associated with implementing and maintaining the expenditure authority. These costs covered a change in vendor and staffing hours associated with nine Joint Application Design sessions.

Monthly per-member expenditures among CHIP members who would have been ineligible if not for the expenditure authority (Measure 1-5)

Figure 3-3 illustrates average per-member per-month (PMPM) costs for CHIP members in the override group. The solid blue line represents the average PMPM costs, the light blue shading represents the 95 percent confidence interval, and the blue dashed line represents PMPM costs among CHIP members who were not part of the override group.

Overall, average PMPM costs among CHIP members in the override group was relatively stable through the evaluation period at approximately $150 before beginning to decline in the middle of 2023. Larger variabilities in the confidence intervals were observed at the beginning and end of the evaluation period due to fewer members in the override group as compared to the middle of the evaluation period.[3-2] PMPM costs for CHIP members who were not in the override group were similar to those in the override group, averaged approximately $150 PMPM throughout the evaluation period.

[3-2] Peaks in PMPM costs in May 2021 and November 2022 were due to several high-cost claims for a single member within those months, resulting in larger confidence bands.

Figure 3-3—PMPM Costs Among CHIP Members with 95 percent Confidence Band

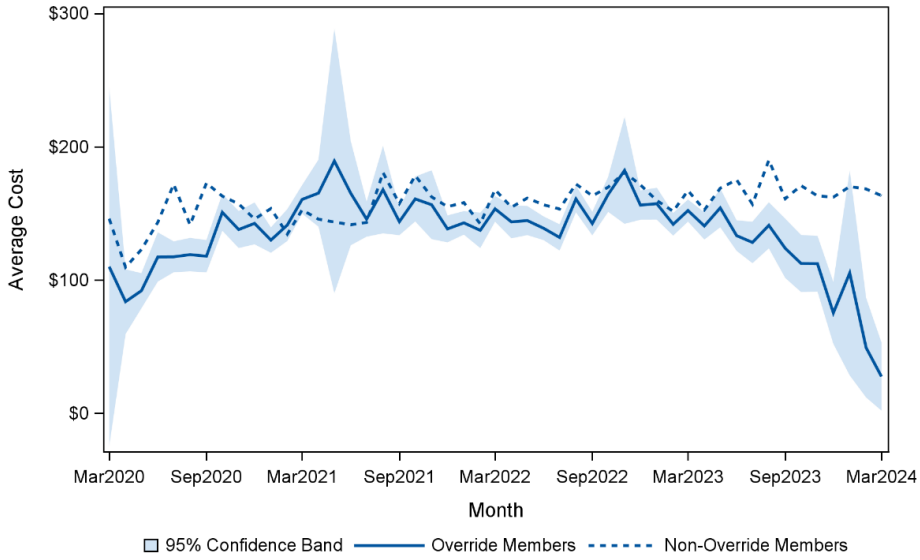
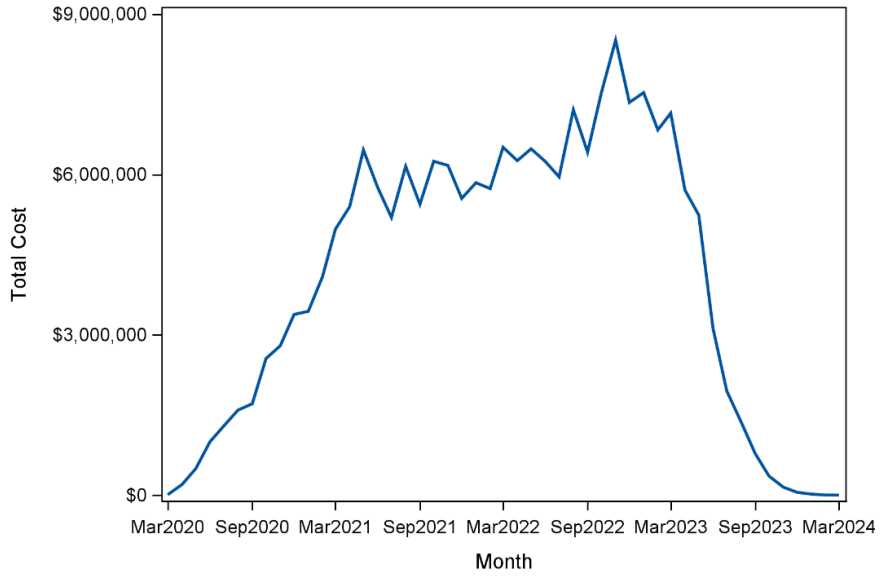


Figure 3-4 illustrates the total costs among CHIP members in the override group. Starting in March 2021, the total monthly costs were approximately $6 million. In November 2022, total spending amounted to $8.5 million, in part driven by single member with high claims costs for that month. Total expenditures decreased rapidly at the onset of the Medicaid unwinding period in April 2023. The total cost of care spent across the entire evaluation period amounted to $200,317,186. This represents approximately 20 percent of the overall cost of care for CHIP enrollees during the PHE. It is important to note this is the cost of care as reported by managed care organization (MCO) plan paid amounts to providers; this does not directly represent the cost to the State Medicaid system or Federal government.

Figure 3-4—Total Expenditures Amongst CHIP Members Maintaining Continuous Eligibility Due to the Amendment



Conclusions

Following the start of the COVID-19 PHE, the continuous eligibility provision for CHIP members allowed approximately 98,000 members to maintain enrollment at some point throughout the PHE. Prior to the unwinding, nearly one-third of CHIP members were covered through the Amendment. Members who maintained coverage through the Amendment generally had similar PMPM cost of care as members without the Amendment, averaging approximately $150 PMPM.

State administrators encountered some challenges in tracking members who maintained Medicaid eligibility under the FFCRA continuous eligibility provisions. AHCCCS created a system to track these members, which required aligning data from the State's PMMIS and an online eligibility system. The distributed nature of the eligibility data contributed to administrative burden. Despite this, AHCCCS noted that the system allowed them to complete CMS-required reporting and create an online, public dashboard, in addition to supporting internal actuarial use.

AHCCCS noted that the Amendment ultimately assisted the State in achieving its goals of reducing enrollment churn, minimizing confusion among members, and lowering barriers to care for children during the PHE.

4. Lessons Learned and Best Practices

The following section outlines the lessons learned and best practices employed for the coronavirus disease 2019 (COVID-19) public health emergency (PHE) Children's Health Insurance Program (CHIP) amendment (the Amendment).

Waiver Application

The time-limited COVID-19 PHE CHIP amendment (the Amendment) was approved under a unique circumstance, allowing State funding to provide continuous coverage for CHIP members retroactively. Given this novel circumstance, the Arizona Health Care Cost Containment System (AHCCCS) found that the Center for Medicare and Medicaid Services' (CMS') flexibility during the waiver application process, along with the provision of pre-populated templates with examples from other states with similar demonstrations, allowed AHCCCS to promptly submit the application and receive approval. For similar situations where time-limited expenditure authorities are necessary, pre-populated templates for submitting the waiver application may work well for receiving timely approval and limiting administrative burden.

Waiver Implementation

AHCCCS maintained eligibility status in two different systems, one of which did not include eligibility data for all members. As a result, the State had to transfer eligibility data from the Prepaid Medicaid Management Information System (PMMIS), which contained data for all members, to the primary online eligibility system. If possible, revising the online eligibility system to query from the PMMIS directly would unify the data sources and ensure that complete data are available in both systems.

Incorporating a mechanism for eligibility override as part of standard operations and reflecting these data in the PMMIS could eliminate the need for states to develop special mechanisms to track continuous eligibility in similar situations. This approach would have allowed the State to identify instances where members of the same household had inconsistent redetermination dates and allow for evenly distributed redeterminations when the unwinding process began. Additionally, it would assist the State in maintaining awareness of PHE policies related to the continuous eligibility provision, alleviating instances where members are discontinued when they should remain eligible.

To address COVID-19 PHE policies, AHCCCS leadership formed a dedicated work group. This group included representatives from operations, policy, and system administrators from various State agencies. Representatives in this group had decision-making capabilities, which reduced potential delays and aided in the development and implementation of policies, while maintaining compliance with federal regulations.

Appendix

Evaluation Design

The evaluation design for coronavirus disease 2019 (COVID-19) public health emergency (PHE) Children's Health Insurance Program (CHIP) amendment to the Arizona Health Care Cost Containment System (AHCCCS) Section 1115 Demonstration Waiver was approved by the Centers for Medicare & Medicaid Services (CMS) on September 28, 2023. The current CMS-approved evaluation design can be found at the following link: https://www.medicaid.gov/medicaid/section-1115-demonstrations/downloads/az-cms-approved-covid-19-chip-evaluation-design.pdf

Measure Specifications

Hypothesis 1: The pause on redeterminations for the CHIP population promoted the objectives of Medicaid.

Research Question 1.1: What challenges did the State encounter when implementing the expenditure authority?

Measure 1-1: Reported challenges that AHCCCS encountered when implementing the expenditure authority.	
Numerator	N/A
Denominator	N/A
Comparison Population	N/A
Measure Steward	N/A
Data Source	Key Informant Interviews
Measurement Period	March 1, 2020, through March 31, 2024
Desired Direction	N/A
Analytic Approach	Qualitative synthesis
Notes for measure calculation	Interviews were conducted in September 2024

Research Question 1.2: What facilitators of success did the State encounter when implementing the expenditure authority?

Measure 1-2: Reported successes that AHCCCS encountered when implementing the expenditure authority.	
Numerator	N/A
Denominator	N/A
Comparison Population	N/A
Measure Steward	N/A
Data Source	Key Informant Interviews
Measurement Period	March 1, 2020, through March 31, 2024
Desired Direction	N/A
Analytic Approach	Qualitative synthesis
Notes for measure calculation	Interviews were conducted in September 2024

Research Question 1.3: How many CHIP members were impacted by the demonstration?

Measure 1-3: Number and percentage of CHIP members.	
Numerator	Number of CHIP members with an override status
Denominator	Number of CHIP members
Comparison Population	N/A
Measure Steward	N/A
Data Source	Eligibility data and AHCCCS-provided list of override members
Measurement Period	March 1, 2020, through March 31, 2024
Desired Direction	N/A
Analytic Approach	Descriptive analysis
Notes for measure calculation	CHIP members were identified as members with eligibility key code '352' or '368'

Research Question 1.4: What were the expenditures associated with providing continuous eligibility for CHIP members?

Measure 1-4: Administrative costs associated with implementing and maintaining the expenditure authority.	
Numerator	N/A
Denominator	N/A
Comparison Population	N/A
Measure Steward	N/A
Data Source	N/A
Measurement Period	N/A
Desired Direction	N/A
Analytic Approach	N/A
Notes for measure calculation	A final total of administrative costs for the Amendment were provided by AHCCCS. No calculation was conducted for this measure.

Measure 1-5: Monthly per-member expenditures among CHIP members who would have been ineligible if not for the expenditure authority.	
Numerator	The total cost of services incurred amongst CHIP members in an override status
Denominator	The total number of member-months CHIP members were in an override status
Comparison Population	N/A
Measure Steward	N/A
Data Source	Eligibility data, claims data, and AHCCCS-provided list of override members
Measurement Period	March 1, 2020, through March 31, 2024
Desired Direction	N/A
Analytic Approach	Descriptive analysis
Notes for measure calculation	—