Arizona Medicaid Expansion Waiver

Overview
Arizona expanded Medicaid to the new adult group effective January 1, 2014. Arizona’s entire Medicaid population is served through a demonstration originally approved in 1982, called the Arizona Health Care Cost Containment System (AHCCCS), which requires individuals to receive health care services through a managed care delivery model. On September 30, 2016, Arizona received federal approval for a five-year extension to its existing demonstration waiver through fiscal year (FY) 2021. The updated waiver establishes a new program called Choice, Accountability, Responsibility, Engagement (CARE), which will test incentives for new adult beneficiaries to adopt healthy behaviors and receive care in appropriate settings.

Populations Covered
Participation in AHCCCS CARE is mandatory for most adults age 19–64 with incomes above 100 percent up to and including 138 percent of the federal poverty level (FPL). This includes adults without dependent children and parents with incomes above the state’s pre-Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended) eligibility levels. Individuals in the new adult group with incomes at or below 100 percent FPL, those with serious mental illness, American Indian/Alaska Natives, and persons considered medically frail are exempt from mandatory participation. However, exempt individuals can voluntarily opt in to the program but will not be subject to premiums or co-payments.1

AHCCCS CARE beneficiaries are eligible, but not required, to participate in a new state initiative that aims to connect beneficiaries to employment supports such as job training. Health coverage provided by Medicaid under AHCCCS CARE is not affected by participation in this state initiative.

Benefits
The new adult group will receive benefits through the state’s alternative benefit plan (ABP).2

Premiums and Cost Sharing
As of January 1, 2017, Arizona requires beneficiaries in the new adult group with incomes above 100 percent FPL to make monthly contributions to an AHCCCS CARE account similar to a flexible spending
account. Beneficiaries are also required to make co-payments for a limited set of services. These payments combined cannot exceed 5 percent of quarterly household income.

Beneficiaries will pay monthly premiums that serve as AHCCCS CARE account contributions, which are set at the lesser of either 2 percent of household income or $25. Third parties, such as charitable organizations or employers, can make contributions on behalf of members without limit. Beneficiaries have a two-month grace period to make required premium payments, after which time they can be disenrolled for non-payment. Individuals can reenroll at any time and are not subject to a lock-out period.3 Beneficiaries can also receive hardship exemptions that exempt one month from CARE program requirements.

Co-payments ranging from $4 to $10 are required for selected services, including opioid prescriptions and refills, non-emergency use of the emergency department, specialist services without a primary-care physician referral, and brand-name drugs when generic versions are available. These payments are applied retrospectively rather than at the point of service and cannot exceed 3 percent of household income in total for any given quarter. Individuals with incomes at or below 100 percent of the FPL who opt in to AHCCCS CARE will not be subject to the cost-sharing structure under AHCCCS CARE.

Beneficiaries in good standing may access funds in their AHCCCS CARE accounts for services that are not covered and roll over funds from year to year without limit. To remain in good standing, beneficiaries must make timely premium payments to their AHCCCS CARE accounts, stay current on co-payment obligations, and complete at least one healthy target. Healthy targets comprise a set of preventive health and chronic disease management activities, such as receiving a flu shot or mammogram or developing a diabetes care management plan with a primary-care provider. Beneficiaries who meet one target can be excused from premium and co-payments for a six-month period of their choice.

**Premium Assistance**

Arizona does not use premium assistance in its Medicaid expansion program.

**Delivery System**

Enrollees receive services through the state’s existing managed care plans.

For a summary of the section 1115 waivers used to expand Medicaid to the new adult group please see Expanding Medicaid to the New Adult Group through Section 1115 Waivers.

**Endnotes**

1 Exempt enrollees who choose to participate in AHCCCS CARE can open and maintain an account without having to meet any of the program’s other requirements.
An ABP offers an option to states to provide alternative benefits specifically tailored to meet the needs of certain Medicaid population groups or provide services through specific delivery systems, instead of following the traditional Medicaid benefit plan. All states that expand Medicaid are required to submit an ABP to denote any differences in benefit coverage between the base population and expansion population, or to note that they are offering the same benefit coverage to all enrollees in the base and expansion populations.

Arizona and the vendor can attempt to collect unpaid premiums and their associated debt, but cannot refer the matter to a debt collection service, report it to credit reporting agencies, file a lawsuit, place liens on homes, seize portions of wages, or sell the debt to a third party.

Reference