Arizona Waiver: Arizona Health Care Cost Containment System

Overview

On September 30, 2016, Arizona received federal approval for a five-year extension to its existing demonstration waiver, the Arizona Health Care Cost Containment System (AHCCCS), through fiscal year (FY) 2021. While the existing demonstration waiver authorized many new program features, including shifting to a managed care delivery model, this brief focuses on waiver features that make changes to eligibility and enrollment policies, benefit design, and cost-sharing requirements for low-income adults not eligible for Medicaid on the basis of disability.

The updated waiver established a new program called Choice, Accountability, Responsibility, Engagement (CARE) to test incentives for certain low-income adult beneficiaries to adopt healthy behaviors and receive care in appropriate settings. Under a waiver amendment approved January 18, 2019, Arizona received federal approval to make changes to the retroactive eligibility period for most beneficiaries, and implement a work and community engagement requirement for the new adult group (AHCCCS 2019). However, AHCCCS policies were not implemented

The information in this issue brief is current as of October 2019. The Biden Administration has since granted the state a one-year extension of the AHCCCS demonstration, but did not extend the AHCCCS CARE program at the request of the state (CMS 2021a).[1] As a result, the eligibility and enrollment, and premium and cost sharing policies described in this brief are no longer in effect, except the waiver of retroactive eligibility (described below).

Demonstration Goals

AHCCCS CARE seeks to accomplish several goals. These goals will inform the hypotheses in the state's evaluation design plan and include, but are not limited to, determining whether the demonstration aided in:

- encouraging members to obtain and continuously maintain health coverage, even when healthy;
- encouraging members to apply for Medicaid without delays to promote continuity of eligibility and enrollment for improved health status;
- containing Medicaid costs;
- increasing employment opportunities; and
- reducing individual reliance on public assistance.

Populations Subject to Waiver Provisions

Most of the provisions of the recent waiver amendments apply to the new adult group, including 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. All Medicaid enrollees, except those individuals discussed below, are subject to the changes to retroactive coverage.

Eligibility and Enrollment

The January 2019 waiver extension changes the effective date of coverage and adds a work and community engagement requirement as a condition of eligibility.

Effective date of coverage

Under the January waiver amendment, Arizona is not required to provide the usual three months of retroactive coverage. Beginning no sooner than April 1, 2019, coverage for nearly all AHCCCS beneficiaries will begin the month in which the member applies. Individuals who are pregnant, women up to 60 days postpartum, and children under age 19 are not subject to these changes.

Work and community engagement requirement

Arizona received approval to require the new adult group age 19–49 to fulfill work and community engagement requirements as soon as January 1, 2020; however, the state has announced its decision to postpone implementation of these requirements until further notice (ACHCCS 2019). In any given month, beneficiaries must meet an exemption or complete at least 80 hours of qualifying employment, training, or education activities (Table 1). Beneficiaries are required to report participation by the 10th day of the following month.[2]

TABLE 1. Work and Community Engagement Requirement Exemptions and Qualifying Activities

Exempt populations	Non exempt populations
Beneficiaries who are: • pregnant women and women up to 60 days post-partum • former foster care youth up to age 26 • determined to have an SMI • receiving temporary or permanent long-term disability benefits or workers compensation benefits from a private insurer or the state or federal government • medically frail individuals • in active treatment with respect to substance use disorder • full time high school, trade school, college, or graduate students • victims of domestic violence • homeless • designated caretakers of a child under age 18, or of a child age 18 who is a full time high school or trade school student and is expected to graduate before he/she turns 19 (one caregiver per child) • caregivers of an individual with a disability • prevented from complying with requirements due to an acute medical condition • disabled, as defined by federal disabilities rights laws, and unable to comply with requirements due to a disability • members of federally recognized tribes • participating in other AHCCCS approved work programs • receiving SNAP, cash assistance, or unemployment insurance income benefits	Required participation in 80 hours per month of some combination of the following: • employment, including self-employment • participation in employment readiness activities (e.g., education (less than full-time), job skills training, life skills training, health education classes) • engaging in job search activities substantially equivalent to those required to receive unemployment benefits in Arizona • community service

Notes. AHCCCS is Arizona Health Care Cost Containment System. SMI is serious mental illness. SNAP is Supplemental Nutrition Assistance Program.
Source. CMS 2019

Penalties for non-compliance. Beneficiaries are permitted an initial three-month grace period. For those who fail to meet the work requirements for any subsequent month, eligibility will be suspended for two months. The suspension period begins the first day of the month that is at least 15 days after a beneficiary has received a notice of suspension. Eligibility will be automatically reactivated at the end of the two-month suspension period. Beneficiaries can reactive their eligibility early, or avoid suspension all together if they apply for and receive a good cause exemption, appeal the suspension, or become eligible through a different pathway.

State assurances. Arizona must make a number of assurances prior to implementing the work and community engagement requirements, including maintaining a mechanism to stop payments to managed care organizations following disenrollment, ensuring timely and adequate beneficiary notices and outreach, and coordinating compliance with the Supplemental Nutrition Assistance Program (SNAP) and Temporary Assistance for Needy Families (TANF). Arizona must also provide appeal and due process mechanisms, make good faith efforts to connect beneficiaries to existing community supports (e.g., non-Medicaid transportation assistance, child care, and language services), ensuring that qualifying activities are available during a range of times and through a variety of mediums (e.g., online and in person), screen individuals for all other Medicaid eligibility groups before determining disenrollment or termination, assess areas within the state that have limited employment or educational opportunities to determine further necessary exemptions, and provide reasonable modifications for individuals with disabilities.

Premiums and Cost Sharing

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). 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 in cost sharing.[3]

AHCCCS CARE beneficiaries must make two types of contributions: (1) premiums that serve as contributions to AHCCCS CARE accounts and (2) copayments for a limited set of services. These payments combined cannot exceed 5 percent of quarterly household income. Beneficiaries can also receive credits for meeting healthy behavior incentives.

Premiums

Beneficiaries are required to pay monthly premiums that serve as contributions to AHCCCS CARE accounts, which are similar to flexible spending accounts. Premiums are set at the lesser of 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 lockout period.[4] Beneficiaries also can receive hardship exemptions for one month at a time. Though beneficiaries otherwise exempt from AHCCCS CARE requirements (including those with incomes below 100 percent FPL) may opt to contribute to accounts, or have a third party contribute to accounts on their behalf, they are not subject to disenrollment for non-payment.

Copayments

Copayments 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 paid monthly.[5] Co-payment charges 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.

Healthy behavior incentives

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

Benefits

The new adult group will receive benefits through the state's alternative benefit plan (ABP).[6]

Delivery System

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

For a summary of the section 1115 waivers used to test new approaches to coverage please see *Testing New Program Features through Section 1115 Waivers.*

Endnotes

[1] AHCCCS CARE policies were never implemented, including the work and community engagement policy. In June 2021, rhe Biden Administration notified Arizona that it was withdrawing Arizona's authority for work and community engagement requirements and notified the state that other elements of the demonstration were under review. The state subsequently requested that CMS extend the full demonstration excluding AHCCCS CARE (CMS 2021a, b).

[2] Arizona must allow beneficiaries to submit documentation in accordance with process requirements for verifying eligibility criteria at 42 CFR 435.916(c) requiring states to provide multiple means of submission (e.g., online, mail, or electronic means).

[3] 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.

[4] Arizona and its 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.

[5] The utilization review occurs quarterly, but the quarterly payments are divided into three monthly payments.

[6] An ABP offers an option to states to provide alternative benefits specifically tailored to 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.

References

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